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MECHANICAL RESTRAINT IN THE TREATMENT OF THE INSANE.

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Read before the Association of Medical Officers and Boards of Managers of the California Hospitals for the Insane.

The subject of restraint as found in asylum practice is one about which much has been written, both for and against, and in many instances the discussions have been fraught with bitterness of feeling, and with expressions of opinion dogmatic and uncharitable in character. One of the first things to be taken into consideration in any discussion is, that opinions do not always constitute facts, nevertheless, all individuals have a right to their opinions, be they good, bad, or indifferent, and the main consideration in the discussion of such opinions is to place a just and impartial valuation upon them without ridicule or condemnation. It is my desire to pursue such a course in the treatment of this subject.

I will now state, as my opinion, that there is not an asylum, either public or private, in this country or elsewhere, where one or other of the following forms of restraint may not be found in actual use: (1) Mechanical restraint. (2) Manual restraint. (3) Medicinal restraint. (4) Seclusional restraint.

Notwithstanding the humane efforts of Pinel to ameliorate the condition of the insane in France, in 1792, Esquirol, in 1818, writes as follows: "I have seen the insane naked, or covered with rags, with nothing but a layer of straw to protect them from the cold dampness of the ground on which they lay. They were kept on food of the coarsest kind; they were deprived of fresh air to breathe, and of water to quench their thirst, and even the most necessary things of life. I have seen them given up to the brutal supervision of jailers. I have seen them in narrow cells, filthy and unwholesome, without air or light, chained in such dens as one might dislike to confine ferocious beasts in."

Paraset, writing about the condition of the insane just prior to the noble efforts of Pinel, makes the following statement: "Vice, crime, misfortune, infirmity, diseases the most disgusting and the most unlike, were there confounded under one common service. The build-

ings were unfit for human habitation. Men covered with filth, cowered in cells of stone, narrow, cold, damp, without air or light, and furnished solely with a straw bed that was rarely renewed, and which soon became infectious ; frightful dens where we should scruple to lodge the vilest animals. The insane, thrown into these receptacles, were at the mercy of their attendants, and these attendants were convicts from prison. The unhappy patients were loaded with chains, and bound like galley slaves. Sometimes enchained naked in almost subterranean cells, worse than dungeons, they had their feet gnawed by rats or frozen by the winter's cold."

The foregoing constitutes a word-picture of the deplorable condition of the insane, as found in the midst of an advanced civilization, and within the environments of one of the most beautiful cities of the world. Conolly, probably the most noted champion of the non-restraint system, after rehearsing the previous mentioned horrors, states, "that down to sixty years from the present day, namely, 1839, or for about 2,500 years, that the general management of deranged persons continued in every respect barbarous in every country, and every age, until Pinel, in France, in 1792, and Tuke, in England, in 1813, effected reforms, great in their time, often interrupted since, and even yet not universally adopted." He further says: "Such facts justify the extremest jealousy of admitting the slightest occasional appliance of mechanical restraints in any asylum. Once admitted, under whatever pretext, and every abuse will follow. No fallacy can be greater than that of imagining what is called a moderate use of mechanical restraint, to be consistent with a general plan of treatment in all other respects complete, unobjectionable, and humane. The abolition must be absolute or it cannot be efficient."

Now the most remarkable statement follows, "that possible cases of exception may occur." I can fully concur with the justly celebrated author's last statement, but stand entirely nonplussed while making the attempt to harmonize it with those preceding it: "The abolition must be absolute;" "possible cases of exception may occur," but when they do occur, if the slightest mechanical restraint is employed, to use the author's own words, "every abuse will follow," and all the horrors of early asylum treatment will again be enacted; that is, mechanical restraint is needed; it will give the best results, and is the most humane procedure in such individual cases, but you must not use it, simply because the dogma has gone forth that it must not be employed. Such statements only go to show how strained an argument may become when used to substantiate some pet, but otherwise erroneous, theory.

Again Conolly says: "As the restraint system comprehended every possible evil of bad treatment, every fault of commission and omission, so the watchful preventative, almost parental superintendence included

in the term non-restraint, creates guards against them all." These are rather sweeping assertions, and it is more than probable that at least 90 per cent. of all asylum superintendents would neither subscribe to one or the other. Both systems, without doubt, contain elements that can be productive of either good or evil, and in this connection it will probably be of interest to know what are some of the requisites necessary to the successful carrying out of the so-called non-restraint system, as outlined by Conolly in the following language: "All this supposes a complete establishment, humane attendants, faithful officers and a chief physician, resolved to allow no excuse for cruelty, or for the indolence which so often leads to cruelty," and frankly acknowledges that without this "there can be no security for its continuance."

If the foregoing conditions are absolutely necessary to carry out this system of treatment, then we must at once admit that we could not bring it to a successful issue in this State, where our asylums are so greatly overcrowded. While he claims conditions and surroundings which probably never have been found in their entirety in any public asylum, as necessary to success in the non-restraint system, he goes on to say that, "these conditions are seldom or never found in asylums where mechanical restraints are retained, as the attendants in such places have a peculiar character; the female attendants are generally morose in aspect, and slatterns; and the male attendants, ill-dressed and ill-mannered, have the appearance of ruffians. The clothing of the patients is scanty and ragged: the food is illy prepared and coarse. The rooms are often offensive to sight and smell, and discomfort and gloom prevail everywhere." While I doubt even the fairness of the latter assertions, as relating to these institutions which allowed mechanical restraints to be used in 1836, I am positive that they are absolutely false as regards like institutions in this State at the present time, and not one of them is managed without using, to a certain extent, mechanical restraint.

It seems incredible that Dr. Conolly should make the statement, "that even the application of a camisole, a pair of wristlets, or soft gloves for even a few moments, should cause wreck and ruin to fall upon the management of any asylum for the care of the insane." The assertion is tantamount to saying, that if in an asylum which has for years been conducted upon the non-restraint system, the management were to make even an infrequent use of mechanical restraint, the excellent discipline, the more than humane attendants, the acme of all that is noble, true and excellent, in the care and custody of this unfortunate class of people, would inevitably retrograde into filth and uncleanness, the female attendants into slatterns, the male attendants into ruffians, and that all the dire inhumanity which characterized the treatment of the insane in former years, would again be reenacted. Such reasoning is fallacious in the extreme, and only goes to show how facts and experi-

ences may be twisted and distorted in the endeavor to uphold and verify a preconceived theory.

While still looking over the work of Conolly we find, when discussing the acute maniacal conditions, coupled in many instances with sudden and morbid impulses, the following language: "Against such sudden impulses it would never be right to resort to mechanical restraint; and any continued holding, or struggling, or overmastering of an irritable patient, belongs to the older system of treatment, and is quite inconsistent with the new. Short occasional seclusion is to be considered a medicine, and if the padded rooms, the real substitutes for restraints in very violent cases, were not of the highest importance, offering, indeed, an auxiliary, without which it is questionable whether or not restraints could be entirely dispensed with in any large asylum." Here there is an admission that the padded room with seclusion, takes the place of the so much detested mechanical restraint, and, as has already been shown, it is regarded by the author as being entirely free from all possible abuse or neglect. However, after having given the description of the padded rooms, as used at Hanwell, in Dr. Conolly's own words, we will proceed to examine into the relative merits of the so much lauded seclusion and padded rooms, and also the greatly vilified mechanical restraint.

He states "that such an apartment at Hanwell, is prepared by a thick soft padding of coir (cocoa-nut) fibre enclosed in ticken, fastened to wooden frames, and affixed to the four walls of the room; the padding extending from the floor to a height above the ordinary reach of the patient. The whole floor of the room is padded also, or covered with a thick mattress of the same material as the padded walls, so that it makes a complete bed. In general, the room contains no furniture, except bolsters or pillows, also covered with strong ticken. If the patient is disposed to suicide, the clothing that he wears is of a strength and consistence, resisting his efforts to tear it into strings to effect his purpose; and the blankets are enclosed in strong ticken cases." Such is a description of that which is to take the place of mechanical restraint. Continuing, he says: "Seclusion is also effected without violence, which the imposition of a straight waist-coat can seldom be."

Will the experience of the general asylum superintendent justify the truthfulness of the preceding statement? I think not. The author says: "After all words have failed, they close quickly upon him, and three or four of them (the attendants) catch hold of him at once, and so dexterously that he can scarcely either kick or strike them, and he is carried into the room like a child, and dropped gently upon his bed or the padded floor." This all sounds very well, but, is it true that a patient in the stages of maniacal excitement, and probably a man of powerful physique at that, can be handled by four strong men as you

would a child? If so, then the attention of four strong men is not needed. And, is it probable that after he has been so gently dropped upon his bed or the padded floor, that he would lie quietly down upon his ticken pillow, and draw his ticken-covered blanket over his restless body, and pass quietly into the shades of dreamland? I think not. Drop him ever so gently and the next moment he is a howling mass of restless activity. Go to the peep-hole as often as you may, and as quietly as possible, and you will, in the majority of cases, find him struggling with his hallucinatory enemies, or trying to escape the fiends of his delusion-racked brain, until exhaustion supervenes.

Again, if the patient be suicidal, and to apply a straight waist-coat means violence, how will it fare with the patient while applying an entire suit, such as recommended by our author as a protection, while in the more than excellently padded room? Again, will it be possible, with the utmost attention to cleanliness, to keep such a room free from the foul-smelling odors arising from such padding material, being frequently soaked with urine and plastered with fecal matter? A negative answer must again be given.

Dr. W. Lauder Lindsay describes one of these padded rooms and its use, as follows: "They are thrust into padded rooms which sometimes have padded floors. There, on a mattress, or without one, but without any kind of a bedstead, the patient is left to himself. The result of this sort of liberty on the subject, on the one hand, and of seclusion, on the other, is, that the patient frequently strips himself quite naked, and crouches in the corner of his 'cell,' exposed to the dangers, already described, from cold. Or, he is restless, mischievous and destructive; amusing himself by tearing to shreds his body and bed-clothing, as well as by stripping off the covering of the padding of the walls or floor of his cell, and dragging forth the padding itself."

Such, then, is a description of a padded room, which, as has already been stated, is to take the place of all that mechanical restraint, the use of which, even to the slightest extent, means a return to all the possible horrors of the past and all the inefficiencies of the present, in the management of the insane. But, is it true that Dr. Conolly, even with his padded rooms, discarded all mechanical restraint? We will let him answer in his own words. "There has, however, been occasional and brief instances of restraint, unsanctioned in some instances by the physician, and which do not appear in this table (meaning a table representing the total amount of restraint employed in the Hanwell asylum during the year 1839), but it correctly represents the total absence of continued restraint during the whole period since Aug. 9th. For patients who take off or destroy their clothing, strong dresses are provided, secured around the waist by a leathern belt, fastened by a small lock.

It is necessary, now and then, to confine the hands, when a blister is applied, to prevent its removal. Those who are in the habit of striking suddenly, tearing the bed clothes, etc., sometimes wear a dress of which the sleeves terminate in a stuffed glove without divisions for the thumb and fingers." From the foregoing language it would appear that Dr. Conolly did use at times the much censured mechanical restraint, and that too at a time when, according to his own writings, the slightest resort to its use, meant a retrogression, from any high standard that might have been acquired, to the worst possible asylum management.

In an article by Dr. A. M. Shaw,¹ the following statements are made: "The same forms of restraint are used in both countries. The only difference seems to be that in England they abolish the name, but retain the thing (restraint), while here we retain the name, but virtually abolish the thing. In confirmation of this statement, I would simply mention the fact, that at Hanwell, near London, the scene of Conolly's labors, I saw more in the way of bolts and bars, coercion and confinement, in one day, than can be found in the Connecticut Hospital for the Insane in ten days. And the babel of noise and confusion in one of the male wards exceeded anything in my previous experiences. From the moment I passed the well guarded lodge, by permission of the uniformed gatekeeper, through the locked front door, had waited twenty minutes in the large, uncarpeted and sparsely furnished visitors' room, until a uniformed turnkey was ready to accompany me through the wards, halls, kitchen and store rooms, an uncomfortable feeling of restraint and helplessness took possession of me, and remained with me, until I was once more outside the high walls. It was the same sort of a feeling one experiences in visiting a penal institution; yet this was Hanwell, the scene of Conolly's life work; an institution which has been held up as a model to be copied, and about which so much has been written."

Doubtless you will infer from what I have already said, that I am an advocate of mechanical restraint. I am an advocate of the justifiable and moderate use of such restraint in the protection and treatment of the insane; that is to say, I would use and employ in such treatment everything that, from an individual study of the patient's condition, would appear to be best and most conducive to his personal welfare and to the welfare of his associates. It certainly would be injudicious and unwise to restrain nineteen out of every twenty patients, and from the simple fact that such a procedure would be pernicious and unnecessary. Upon the other hand, it would be equally unwise not to restrain the twentieth, who is destructive, dangerous and vicious. The moral discipline of the patient's associates, as well as his own safety and welfare, demands that he shall be restrained; and doubtless one of the forms of

¹ American Journal of Insanity, 1879.

restraint, mentioned at the commencement of this paper, will be chosen, namely: manual, mechanical, medicinal, or seclusional. In the choice, I should demand as my right, to choose that form which would best meet the exigencies of the case, and without any reference to the creeds or dogmas of other people.

I believe that investment of authority which places in the hands of a superintendent and his staff of physicians, such remedies as are named among the most virulent of vegetable and mineral poisons, to be administered to the insane as may be deemed needful, which also provides the strong and padded room, and which invests these same individuals with the power to select and employ men and women, to act as the constant guardians and supervisors of the alienated, and who are empowered to use such manual restraint as may be conducive to their welfare and the welfare of their associates. I repeat, that the investment of authority which places in the hands of a superintendent and his staff of physicians, all of these means for the care and treatment of the insane, and trusts to their judgment and skill to use them justly and humanely, will certainly not refrain from also placing in their possession mechanical restraint, and that intelligence and humanity, which will insure the proper application of the former, will certainly insure the correct use of the latter.

It hardly seems necessary to state, that the grand central figure around which all these methods and means are grouped is the patient. It is the patient and his welfare that is to be considered, first and last. The method and means should always be held subservient to the best interests of these people; and that being the case, if it were judicious every asylum officer would abolish restraint at once and for all. Even those who advocate its use at proper times, and when absolutely needed, still believe in reducing its applicability to the minimum. The principle of restraint in some form underlies the whole superstructure of the humane care and treatment of the insane. If this were not true, every State in our country could and would not boast of its palatial homes dedicated to this class of suffering humanity, wherein can be controlled those who elsewhere are uncontrollable.

While I consider some form of restraint admissible and absolutely necessary in the care and management of the insane, still I can but honor the humane spirit of Conolly and all others who may have been instrumental in correcting the abuse of mechanical restraint. It is probable the pendulum of public opinion swayed too far in the direction of their radical teaching; but to assert that good has not been accomplished would be to make a statement unfair, unjust and untruthful. The pendulum of opinion is slowly swaying back to a position midway between the two extremes, which doubtless constitutes the safest ground, both for discussion and application.

In closing this paper, I would simply reiterate the words of Dr. Godding: "We claim, then, for the insane man in America, the right to the highest individualized treatment looking to his cure, and for the American superintendent the right of private judgment, untrammelled by any dictum."

ENTOTIC OR SUBJECTIVE NOISES.

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Among the many unsatisfactory cases the aurist has to treat, the most unsatisfactory, I feel safe in saying, are those in which the principal cause of complaint is subjective or entotic noises.

The cause of these noises is known in many cases, in others it is only suppositional. They may be classified as central and peripheral. I apply the term central to those noises that are produced exclusively by abnormal conditions or pathological changes of the structures of the labyrinth; and peripheral, to those due to causes external to the labyrinthal structures.

The character of these noises varies widely, nearly every patient describing them differently. There are some, however, that may be called types; as the chirping of crickets, noises of tree toads (sounds peculiar to a summer night), the rushing of water, escaping of steam, humming, buzzing and pulsating sensations.

As a rule, the noises are not continuous, but leave the patient with intervals of freedom; in some they are periodical, coming on at certain times of day, and disappearing as regularly. In the most severe cases they never entirely disappear. Usually the noises cease, or are less troublesome before a storm, by low pressure, as indicated by the barometer. In a few instances, however, I have found quite the opposite to be the case.

The noises are most troublesome when everything surrounding the patient is quiet, and consequently, they become most annoying at night; in fact, some complain of disturbance only at that time, it being often so loud that it prevents the patient from sleeping. I have seen a number who only hear the noises when the better ear is closed, so that they are unable to sleep on that side.

In most cases the noises disappear, or, perhaps, escape the patient's notice, when they are in the midst of noisy surroundings, as on the street or in a sleeping car.

One peculiar feature I have noticed, when both ears are affected, is that the noise often changes from one ear to the other. The patient states that the noise ceases gradually on the one side and seems to pass over the top of the head and into the other ear.

Different patients refer the noises to different points; some say it is in the ear, others that it is in the head and cannot locate it in any particular point, while others describe the noise as coming from some distant point, and having a muffled sound.

The cause of these noises is difficult to arrive at in many cases, in some absolutely impossible, and our methods of differentiating between middle ear and labyrinthal affections are very faulty. The latter form of trouble I shall dismiss with a few words.

Among the causes that produce noises in the labyrinth are, increased pressure, either from exudations within, or tumors, etc., without; anemic and hyperemic conditions, the action of certain medicines, particularly quinine, which probably produces one of the foregoing conditions.

As these noises always accompany a disturbance of hearing, the same methods that are used in diagnosing the latter will, in most cases, lead us to the source of trouble in the former. The pulsating noises are, of course, recognized as coming from the vessels, particularly the carotid, which passes in such close proximity to the ear. Probably some of the noises emanate from the jugular fossa, as suggested by Bondet, and others, no doubt, are produced by muscular contraction, particularly of the masseter.

We know that the noises are most frequently met with in middle ear trouble. One form of noise I have found almost characteristic of chronic catarrhal otitis, the chirping of crickets, ticking, and those I have already mentioned as "summer night noises." In all patients where I have observed this peculiar type, a chronic catarrhal otitis, of a dry, non-secretive form, was present.

It is seldom, however, that the patient comes to the aurist on account of the trouble caused by this form of noise, but because of the difficulty in hearing. Sometimes the patient will not mention the noise until questioned in regard to it, and will then, as a rule, state that the noises are not disagreeable. In some instances they find them pleasant, and think they are blessed beyond other folks. One lady patient who had trouble in one ear, said all she had to do was place her good ear against the pillow on going to bed, and she had the pleasures of sleeping in the country, as she could hear the katydid, crickets, tree toads, and other little animals that went to complete the pleasure of a summer night in the country to her.

On examining the ear in these cases we often find nothing apparently abnormal, but usually we can discover a slight change in the membrana tympani, the reflex being dull and the membrane retracted. The hearing is not much affected for ordinary conversation, but the patient fails to hear the watch unless held closely to, or in contact with the ear. A more advanced state of this catarrhal otitis is characterized by the louder and more annoying noises, such as rushing of water, escape of steam,

and ringing, which are not continuous, but give way occasionally to the less disagreeable forms. A still more advanced stage differs from the last in that the noises are more persistent and more annoying.

In these catarrhal troubles the cause of the noises is probably the changes in the mobility of the ossicles and the retraction of the membrana tympani, which forces the stapes into the oval window. As a rule the noises are commensurate with the damage done in the middle ear. We know that with the progress of catarrhal otitis the chain of ossicles becomes more and more rigid, and the membrana tympani thickened and inflexible. In the most advanced stages we find the ossicles perfectly rigid, and bound to each other and the walls of the tympanum by bands of connective tissue, the membrana tympani is thickened, filled with chalky deposits and immovable, the stapes is forced into the oval window, and in many cases ankylosed there. The chain of ossicles, which in their normal condition are peculiarly adapted for the conveyance of sound waves, transmit, in the rigid state, every form of vibration, and as every vibration affecting the optic nerve is received in the nervous centres as sensation of light, so every vibration transmitted to the acoustic nerve is received as sensation of sound.

In purulent otitis the changes occurring are practically the same as regards the effect; after the breaking down of the membrane it differs only in the ossicles being drawn backward by retraction of the muscles and cicatricial tissues and thus held firmly.

We know that pressure on the oval window produces the ringing noises; "box the ears and make them ring," is a familiar saying to most of us. The ringing resulting from explosions, loud reports and in diving, is also equally familiar. The cause of this ringing is the compression of air in the external auditory meatus, the pushing in of the membrana tympani and with it the forcing in of the chain of ossicles. In catarrhal and other troubles, which produce, or are the result of a stoppage of the Eustachian tube, the resultant conditions are the same. Quite a number of cases, however, have come under my observation, where the membrana tympani was changed almost beyond recognition and the hammer immovable, yet there were no subjective noises and the hearing was very little, if at all, below normal. These exceptions must be explained by the fact that the incudo stapedial articulation has escaped, leaving the stapes in a condition to perform its functions normally.

The prognosis in these cases, excepting where they occur in acute trouble, must be regarded as unfavorable. They are unrelieved by treatment, but fortunately the subject becomes accustomed to the noise. Many patients, however, find it impossible to accustom themselves to this condition, and until lately they sought relief in vain. Existence to

them becomes unbearable; miserable as the days are, the sleepless nights are more distressing, and it is no wonder that we find them in a state of melancholy or hysteria. If there is any predisposition to insanity it soon manifests itself under these conditions. According to Schwartz, Koppe and Gruber, many of the hallucinations of hearing of the insane are caused directly by ear trouble.

In purely labyrinthal affections I have not seen any cases where the noises have been intolerable. They either cease with the improved condition or disappear as the trouble becomes worse, stopping entirely when complete deafness supervenes.

As to treatment, if the cause is unknown, the patient should have the benefit of such measures as have proved successful in other hands if not in our own. It is unnecessary for me to enumerate the list of remedies, and I will only mention those that are most popular to-day. These are pilocarpin, tincture of arnica, amyl nitrite, bromethyl, cocain, the bromides of soda and potash, and electricity. In the purely nervous type, hypnotism proves successful for a time, but on account of the psychical condition of the patient it is not always safe.

Massage of the ossicles by Dr. Maloney's otophone, has also been advocated. I wish here to mention a method of massage that I have practised myself for some time, namely, with a tuning-fork, particularly with the deep sounding fork, by inserting the base of the instrument (properly fashioned) directly into the external auditory meatus. The advantage of the deeper fork is that the vibrations are more forcible and extensive, and continue longer. In my opinion the sound has nothing to do with the treatment, as the result sought for is the mobility of the ossicles.

In those cases where the cause is in the middle ear, the usual remedies should be tried; if these fail and the condition of the patient demands, we should not hesitate to adopt operative measures. All sorts of operations have been devised to lessen the tension of the ossicles. The spring probe of Lucae, perforation of the membrana tympani, division of the tensor tympani, division of the thickened anterior and posterior folds, etc.

The removal of the ossicles for the relief of suppuration has been practised for a number of years both in Europe and in this country, but it is only of late that the operation has been employed for the relief of deafness and tinnitus. What the cataract operation is to the eye, this operation is to the ear. In each case the diseased and obstructing medium is removed to give the sensory-producing vibrations access to the essential organ of vision or hearing. In either case if this essential organ is abnormal and incapable of performing its functions the result is *nil*.

The operation was first performed in Europe by Lucae, afterwards by Schwartz, Urbantschitsch, Kessel, Stacke, Kretschmann, and others. In this country it was first performed by Sexton, of New York, without any previous knowledge of its having been done in Europe, afterwards by Ferrer in this city, by Colles in New York, and others, I might say, of the Sexton school.

The operation, according to Sexton's method, is performed through the external auditory meatus. It is comparatively simple. The operator must be familiar with the parts involved, must have a certain amount of skill, a good light, and proper instruments. The details of the operations, together with the results, are published in Sexton's book¹, and in two articles by C. J. Colles². The operation as at present performed in Europe is that introduced by Stacke³, and Kretschmann's modification of it. It consists in the separation of the auricle and drawing forward of the cartilaginous meatus, thus laying open the field of operation that it may be explored by direct daylight. If necessary the outer and lower wall of the attic is chiseled away.

This operation is no longer to be looked on as experimental. The number reported from Europe is now in the hundreds, and in this country Sexton alone reports 60, while other aurists increase the number into the hundreds. In the majority of the cases the results have been highly gratifying, both in regard to improved hearing and in relief from the troublesome noises. As Urbantschitsch observes, one curious feature of the operation is the improved condition in the other ear after operating on one side.

There remain, however, a certain number of cases in which the stapes is bound or ankylosed in the fenestra ovalis, and which consequently are unimproved by any of the methods mentioned. I have been able to find but one case reported, by Kessel, in which an attempt was made to loosen the adhesions, and the result was favorable. This operation has been avoided for fear of inducing an inflammation of the inner ear with the attendant unfavorable results.

In these days of advanced aseptic and cranial surgery, I see no reason why it should not be performed where indicated. The danger of injuring the labyrinth where its functions are destroyed is, I believe, more imaginary than real. The cases are not a few in which portions of the cochlea, and semi-circular canals, and in fact the whole structure of the inner ear have been sequestered and exfoliated.

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¹ The Ear and its Diseases.

² Deutsche medicinische Wochenschrift, No. 28, 1887. American Journal of Medical Sciences, May, 1891.

³ Monatschrift f. Ohrenheilkunde, Nov. 1891.

A CASE OF HEALED TUBERCULOSIS, WITH AUTOPSY.

By ALBERT ABRAMS, M. D., San Francisco, Cal.

The following case is reported as a contribution to healed cases of tuberculosis, based on clinical and autopsical examination.

E. T——, aged 27, referred to me by Dr. M. E. Weldon, of this city, on the 16th of October, 1891, showed on examination, absolute evidence of cavity formation and consolidation of both pulmonary apices. There was also dilatation of both ventricles of the heart; irregular and rapid heart action; accentuation of the cardiac tones; systolic murmur at the apex and pulmonary artery, especially loud in the latter situation, and conveyed some distance therefrom. The sputa contained a very large number of tubercle bacilli. The subjective symptoms were those of phthisis. Diagnosis; pulmonary tuberculosis; mitral insufficiency.

The patient was placed on the following treatment: The pneumatic cabinet was used daily. Internally, creasote was given in drop doses, gradually increased until at the time of discharge, a drachm of creasote was taken daily. The patient increased 28 pounds in weight up to the time of discharge, which was on the 15th of February, 1892. The sputa had disappeared and bacilli were no longer demonstrable. The physical signs of cavity formation were no longer recognizable. The increased area of cardiac dulness, accentuated cardiac tones, and murmurs persisted.

The patient was directed to continue the creasote and report further developments. Nothing was heard about him until the 24th of June, 1892, when a death certificate was presented for my signature. Dr. J. W. Jones, who was hurriedly summoned to attend him on the day of his death, informed me that he had expectorated large quantities of blood.

Autopsy: Present, Drs. Jones and Tully. Only the thoracic viscera were examined. Heart—The left ventricle was normal; the right ventricle dilated. Valves normal. The pulmonary artery was slightly narrowed. Lungs—The pleura over the apices of both lungs showed cicatrices, which corresponded with cavities, about the size of walnuts in both apices. The pleura was thickened, especially at the apices, to the extent of one-fifth of an inch. The cavities in both apices were completely encapsuled by dense fibrous tissue, and presented no external communication. The left lung was very much retracted, adherent, and showed the characteristic appearance of interstitial phthisis. The lower lobe of the right lung was uniformly infiltrated with blood, and the bronchus communicating with the same contained a large quantity of blood. The anatomical diagnosis was: Healed tuberculosis; dilatation

of the right ventricle of the heart ; interstitial phthisis ; pulmonary apoplexy.

The clinical diagnosis of dilatation of the left ventricle of the heart was not confirmed at the autopsy. This error would not have been committed had the precaution been taken after determining the area of superficial cardiac dulness, to note if this area were diminished after deep inspiration, or increased after forced expiration. In the present case, a diagnosis of lung retraction by this manœuvre could have been made after excluding pleural adhesions and lung consolidation adjacent to the area of cardiac dulness. Dilatation of the right ventricle was explainable by the abnormal condition of the lungs.

No cause for the cardiac murmurs could be ascertained, and I am inclined to believe that they were induced by the narrowing of the pulmonary artery, superinduced by retraction of the right lung; the calibre of the artery being reduced, as would any other elastic tube when stretched. This theory, of course, requires further confirmation before acceptance.

The cause of death was pulmonary apoplexy—*i. e.*, extreme engorgement of the lower lobe of the lung, consequent upon dilatation of the right ventricle and rupture of the pulmonary capillaries. No hemorrhagic infarctions were found.

435 Geary Street.

APPENDICITIS OR PERITYPHLITIS; WHICH?

By W. R. CLUNESS, M.A., M.D., Sacramento, Cal.

Read before the Sacramento Society for Medical Improvement.

In a discussion at a meeting of this Society a few months since, upon the subject of "appendicitis," I took occasion to observe that the members were alluding to *perityphlitis*, and that, in my opinion, the word appendicitis was inappropriately used to signify pathological changes which might or might not have resulted from disease of the vermiform process. Since then I have given the subject some attention in connection with three cases of so-called appendicitis that came under my care; and besides, have carefully read most of the current literature bearing upon it as published in the journals, and I have become more than ever confirmed in the belief that physicians and surgeons generally use the word appendicitis inappropriately.

The cases referred to were possibly, but very improbably, due to the accidental introduction of foreign substances into the appendix vermiformis, inducing appendicitis first and perityphlitis secondly. When it is recollected that only in exceptional cases is a foreign body of any kind found in the appendix, and that in many instances no inflammation whatever of that process had been revealed, either in *post-mortem* examination or during surgical interference, we may safely conclude that

appendicitis did not exist. I shall not weary you with a detailed history of either of the cases mentioned, for I am confident you would all agree that in each instance traumatism was the exciting cause. Nor shall I more than ask you to refresh your memories with the anatomical relations of the appendix with the cecum and adjacent structures, for with these you are doubtless as familiar as I am; I may, however, be permitted to remind you that the appendix is an embryonic process of the cecum, located in the right iliac fossa, and surrounded by connective tissue. It should also be recollected that appendicitis *pur et simple* may exist without involving the tissues surrounding it, and that they—the tissues—may likewise become the seat of inflammation without involvement of the appendix; and further, that typhlitis frequently takes place without the inflammation extending to either the appendix or the connective tissue around it. In truth, it is believed that a large percentage of the cases of so-called appendicitis could, by careful differentiation, be demonstrated to belong to this classification.

Not infrequently, also, cases have been reported that were due to typhoid, or dysenteric ulceration of the cecum, or to tubercular degeneration. And, as stated, traumatism induces many cases. One of this kind occurred recently in the person of a young farm-hand, who, while endeavoring to raise a large forkful of hay, placed the end of the handle of the fork in his right hand, then resting the hand over the right iliac fossa as a fulcrum, he inflicted serious injury in that region by his effort to lift the hay. Inflammation ensued, necessitating the most active antiphlogistic measures to prevent suppuration. Cases of a similar nature are not uncommon; you have all doubtless seen many of them. They are not cases of appendicitis, or of typhlitis either; nor is a case of cellulitis, even when primarily due to diseased action in the appendix vermiformis, one of appendicitis, any more than the meningitis due to the extension of inflammation or the escape of pus from the middle ear to the meninges is otitis media.

Why, for example, would it not be equally correct to say that a patient suffering from hepatitis, or even hepatic abscess, consequent upon the impaction of a gall stone in the cystic duct, was ill of inflammation of the ductus communis choledochus. Or, if you please, why not call hepatitis by some name indicating disease of the rectum when the inflammation is known to be due to the decomposing products of a pile or to an ulcer near the anus, as to say that a case of cellular inflammation in the iliac fossa was appendicitis? It has occurred to me that the majority of cases coming under observation are those in which the initial lesion occurs in the cecum, whence it extends to the connective tissue around and behind that intestine, without involving the appendix at all. Such cases are properly designated by the term perityphlitis, as indicated by its Greek derivation. Then, again, cases have been re-

ported in which perityphlitis was due to the extension of perinephritic and psoas abscess, because of the continuity of the subperitoneal connective tissue. Blows, kicks, severe compressions, and other injuries have also been known to cause inflammation in this region; so that it is frequently quite impossible to determine whether the cecum or the appendix, or psoas or perinephritic abscess, or an injury has been the exciting cause of the diseased condition. We always know, however, by the attendant evidences, when perityphlitis is present, be the cause what it may, and I am persuaded that nosologically, the condition so generally known as appendicitis, is inappropriately designated.

The etiology, the science of causes, is of the utmost importance in all cases, and should be considered as fully and determined as correctly as practicable. The nomenclature of diseases should also be accurate, and should be based upon the pathological changes which may have been superinduced. The term appendicitis presupposes the inflammation, not only to originate, but to be confined to the appendix, whereas, such a condition is exceedingly rare. Finally, it is conceded that a large percentage of the cases of disease under consideration are primarily due to inflammation extending from the cecum through the appendix to the surrounding cellular tissues; but so, also, is that form of peritonitis occurring in the puerperal state due to the septic products which first invaded the uterus or its appendages, yet that condition is never termed hysteritis. Nor is a bubo in the groin ever known by any other name, whatever its cause, although its origin is usually a chancroid on the penis, or some other portion of the sexual organ.

Within the past few days my attention has been invited to an interesting article on the subject: "Is Appendicitis a Primary or a Secondary Disease?" by Dr. P. C. Barker, of Morristown, N. J.¹ The author says it will probably be admitted by most physicians of middle age, that appendicitis is much more prevalent now than it was 20 or 25 years ago. Catarrh of the cecum had heretofore been recognized as a concurrent condition, but it had not been suggested that a diseased appendix demonstrates the preëxistence of a diseased cecum; on the contrary, the diseased cecum had been universally regarded as secondary to the appendicitis. For more than 30 years he had made it a practice to examine the cecum and appendix in every case of abdominal section, and generally found it very difficult to locate the orifice of the appendix, even after the cecum had been laid open. In some instances it had to be cut across and a probe inserted, before the slit like orifice in the cecum could be discovered. Unless, therefore, there was the preëxistence of a condition favoring the introduction into the appendix of seeds or other foreign substances, it is extremely improbable that they could

¹ New York Medical Journal, July 16, 1892.

find entrance. The anatomical peculiarity of the cecum favors this accident. The meso-cecum is often so insufficient as to constrict the lumen of the canal at the junction of the cecum and ascending colon, and thus peristalsis is interfered with ; or, the transverse colon, when full of fecal matter, descends, and drags with it the meso-cecum. The result is the same in either instance, peristalsis is interfered with, and the cecum is never entirely emptied. Swarms of microorganisms inhabit these retained masses, and gases are generated which still further distend the cecum, and induce a relaxed or paretic condition. He therefore concludes that distension with paresis is the usual predisposing cause of appendicitis, for during this condition only could seeds or other foreign bodies find entrance. Pathogenic microbes, however, would be likely to find their way into the appendix much earlier than foreign substances, such as seeds, concretions, etc., and as bodies of appreciable size are oftener absent than present in appendicitis, they are the exciting cause of the inflammation.

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DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By WALLACE A. BRIGGS, M. D., Sacramento, Cal., and

HENRY GIBBONS, JR., M.D., Professor of Obstetrics and Diseases of Women, Cooper Medical College, San Francisco, Cal.

Total Ablation of the Uterus for Large Fibroid and Fibro-cystic Tumors.—Large subperitoneal and pedunculated tumors of the uterus may be removed through a median opening in the abdominal wall, after tying them as low as possible, detaching their points of adherence, and cutting them in pieces, if necessary. With this class of tumors the operation is not more dangerous than that of extracting a cyst from the ovary or from the broad ligament. On the contrary, if the growth is interstitial, the body of the uterus and its annexes must be removed. In these cases the cervix and the small remaining portion of the uterus form a stump, which most surgeons prefer to treat by the extra-peritoneal method, as it is more rapid, does not expose the peritoneum to infection, and allows the operator to prevent hemorrhage and apply dressings. However, there are cases in which the pedicle is so large and so short that the intra-abdominal method is indicated, and the stump may be reduced after tying it in half and closing the wound by sutures. When the tumor entirely fills the body of the uterus and the cervix, the total ablation of the organ becomes necessary, and this operation, first attempted in 1869, has since been performed many times with the best results. After opening the abdomen, withdraw the tumor by the help of a long and curved trocar, place a rubber band as near as possible to the cervix, hold the band with a pair of long bladed forceps, and amputate the tumor a few centimetres above the band. If there are several lobes, remove them in succession, after applying rubber bands as low as possible. When nothing remains except the cervix and the lowest part of the uterus, carefully detach the bladder and rectum, if necessary, tie or compress the small vessels belonging to them, place a metallic thread either above or below the

rubber band, according to circumstances, and twist it by means of a ligature until it breaks just one centimetre from the uterus. Then cut off the stump, close to the metallic thread, taking care to remove the mucous membrane, in order to lessen its volume as much as possible without loosening the rubber band, reduce the stump, and close the abdominal wound by sutures. It remains only to take away the cervix, the stump and the metallic band, and this is easily done by the vaginal method, according to the rules laid down for the removal of small uterine tumors. The following conclusions may be deduced from the results of this new method of total extirpation of the uterus: (1) Total ablation of the uterus is indicated in many cases of large fibroid and fibrocystic tumors of this organ, and is best effected by a combination of the abdominal and vaginal methods. (2) This method permits a more rapid removal of the uterus and its annexes than the intra- and extra-peritoneal methods. (3) It increases the domain of surgery by increasing the number of cures.—*Journal de Médecine de Paris*, June 19, 1892.

False Diphtheritic Membrane.—The experiments and researches of Klebs and Loeffler, Roux, Yersin, and others have conclusively shown that the false membrane in diphtheria is the medium of the extension of the disease, hence the efforts of the physician must be directed toward the prevention of the development of this membrane. Our knowledge of the conditions necessary to the cultivation of the diphtheritic microbe is here of great use. Loeffler's bacillus requires an alkaline medium; the presence of an acid impedes its culture, and many cases of diphtheria have been cured by applications of lemon juice. In the service of M. Debove, at the Andral Hospital, this treatment has been found most efficacious; in serious cases the applications must be very thorough, and we may use with advantage either the carbolic mixture advised by M. Gaucher, or the sulphurated phenol recommended by M. Josias. This treatment is based upon our knowledge of the virulent properties of Loeffler's bacillus. If an acid arrests its development, the presence of an antiseptic may cause its death, and early and judicious treatment may achieve the best results. By combatting the development and extension of the false membrane we may often check the progress of the infection, since the exudation may be regarded as the entrenchment, whence the pathogenic agent directs its attacks against the system.—*Médecine Moderne*, June 23, 1892.

Matrimonial Sterility.—After a reference to English statistics showing that one marriage out of every eight is unfruitful, and to his own experience in Hamburg, where, in 200 women, 23 were unfruitful, DR. L. SEELIGMANN discusses the causes of sterility, and finds that in fully 50 per cent. of the cases the husband is at fault, largely through antecedent gonorrheas and their complications. Sterility in the wife arises largely from mechanical causes, the prevention of the contact of the spermatozoa with the ova, for the relief of which many modes of treatment are in use and have been proposed. Attention is drawn by the author to two curative methods, which he regards as the principal curative agents in female sterility. These are gynecological massage and gymnastics, as taught by Thure and Brandt, and gynecological electrotherapy, as taught by Apostoli. It is shown that by massage, ovarian swellings and tenderness may be reduced, when these have resulted from oöphoritis and perioöphoritis; that the normal function of a tube, rendered impervious by perimetritis and salpingitis, can be restored, and that a like result may be accomplished when a retroflexed uterus is bound down by old inflammatory adhesions; that in the same manner

old chronic catarrhs and erosions are curable. Massage is also applicable in recent, and frequently also in old cases of gonorrheal epididymitis.—*Medical and Surgical Reporter*.

In this connection the following remarks of DR. PRICE, of Philadelphia, before the Southern Surgical and Gynecological Association, are interesting: "When a resident physician in the old Philadelphia Dispensary, it was there the rule not to treat venereal diseases in the institution, but I asked, as a special favor of the Secretary, that I be permitted to treat all venereal diseases after hours, as I was anxious to have a little experience just then in that direction. Consent was given, and I soon built up a huge clinic for the treatment of venereal diseases. I call attention to this to verify my position in gynecology. I soon had a clinic that took me an hour and a half or two hours to manage. I had a large number of cases of gonorrhea, chancroid, bubo, phimosis, prostatic trouble, vesical and renal troubles. I took my meals, my dinner and sometimes my breakfast, with my brother. I had a room in the dispensary. My rule was to go to a restaurant near by to get my lunch, and sometimes my breakfast, if I had slept late. I soon discovered that it was impossible to dine at a single restaurant without being waited on by some one whom I was treating for bubo or gonorrhea. I had to give up going to restaurants to take my meals. Some of these patients would salute me: "Hello, Doc., what will you have?" I had to go back to my brother's, and take my meals with him. I call your attention to this matter to emphasize the fact that I have since operated on the wives of those men for huge pus tubes, ovarian abscesses, not by the dozen, but by the hundreds. I am speaking to prominent practitioners, men of large experience and good judgment. I am speaking from the standpoint of a specialist. For the last six years I have treated more cases of pelvic diseases than anyone else in Philadelphia."—*Atlanta Medical and Surgical Journal*.

Oophoritis—Its Causes and Treatment.—Contrary to the experience of other gynecologists, says DR. THOMAS MORE MADDEN, acute oöphoritis is by no means uncommon in the experience of the physicians at Mater Misericordiæ Hospital. It is frequently found in those admitted for dysmenorrhea, occurs as a result of uterine sepsis or puerperal inflammation, is a frequent consequent of gonorrheal infection—to which the ovaries are more sensitive than the testicles—occasionally arises from cold, especially soon after delivery; from local injury, acute tubercular disease, the use of emmenagogues, and of substances employed to procure abortion, the metastasis of rheumatism, or of other diseases which in the male might similarly produce orchitis, and lastly inordinate or premature sexual excitement, or coition soon after parturition, or too near the menstrual period. The disease is marked by continuous dull or burning localized pain just above the symphysis pubis, increased by motion or touch; tumefaction of the ovary, not always to be detected without rectal examination; more or less constitutional febrile disturbance; generally a high temperature, nausea or vomiting. Nothing new in the treatment is offered. Poultices, anodyne stupes, leeches, salines, hot baths, vaginal irrigation, opiates, bromides, iodide of potassium, antipyrin, etc. The author believes the chronic form of oöphoritis is also much more common than usually recognized, and gives rise, not infrequently, to symptoms wrongly ascribed to other morbid conditions. Chronic oöphoritis is, in the majority of instances, the direct sequence of the acute or the gonorrheal form; it also arises from tuberculization within the ovary itself. "No disease met with in gynecological practice is probably more

obscure or insidious in its inception, or less definite in its general symptoms, of which the most constant are anemia and hysteria, associated with or dependent upon disordered function of the diseased ovary—*i. e.*, imperfect and generally painful menstruation." The diagnosis is to be cleared up by conjoint or bimanual examination *per rectum* and externally, on which the enlarged and tender ovary may, if present, be detected. Displaced ovaries, if not restored to normal position, are liable to inflammatory changes. Acute inflammation, if not treated, or neglected, seldom terminates by resolution, but passes into the chronic form; the ovary frequently disintegrates and suppurates, hyperemia of adjacent parts takes place, leading to serous plastic or hemorrhagic exudations or effusions, or the ovary may become atrophied, hard and nodular, or present no remarkable change, even after years of chronic disease. In treatment nothing is more serviceable than counter-irritation by liniment of iodine or blister. This should be followed by inunction of oleate of mercury and morphine, and the long continued use of bichloride of mercury—one twenty-fourth of a grain thrice a day. With this may be combined iodide of potassium and the bitter tonics. The bromides and valerianates, quinine and iron are not to be omitted from the treatment. The author quotes approvingly from DR. EMMET in disparagement of the careless use of opium, through which the opium habit may be contracted, but takes a more hopeful view of the general treatment of these cases than that authority, having frequently seen them amenable to treatment. Even when abscess has formed, aspiration by washing the cavity with iodized solution has proved efficacious. When this is impracticable, or fails, extirpation of the gland is advised, or the gland and tube may be removed together.—*Dublin Medical Journal*.

The Blended Tocci Brothers.—This duplex monstrosity, born in Italy nearly fifteen years ago, is described by DR. R. H. HARRIS as the most remarkable the world has seen since the death of its Scotch analogue in 1518, at the age of 28 years. On an average, but two cases of this form of deformity are born in a century, and they rarely live beyond their first year. These Locano twins have two heads, a double thorax and single abdomen, with two sets of organs, four arms and two legs. There was but one placenta, and a single cord. They now weigh 95 pounds. Their arms are well developed, which is the reverse of their legs, one of which is club-footed. Each has two lungs, a heart, a stomach and intestines. Recently, when traveling, one became sick and vomited, while the other was not even nauseated. Each has a bladder, but there is only one urethra and one rectum. Each urinates and defecates independently of the other. The twins have different tastes, desires and feelings. They converse a great deal together. Each controls one leg, and experiences no sensation when the other, or the arms and other parts of the brother are pricked.—*Medical News*.

Milk Laboratories in Artificial Feeding.—DR. T. M. ROTCH, of Boston, has established a laboratory in that city for the purpose of providing proper food for infants, for which prescription may be made, precisely as in the case of drugs. Slight changes in the percentages of the elements of milk may have an important bearing upon the digestion of infants. It is sought to correct these objections, and to provide specially prepared food for special cases. A cream separator, sterilizer, etc., are used. The writer states the proportion of solids in the 100 parts of human milk to be, of fat, 4; sugar, 7; and albuminoids, 1.50. He holds that it is not necessary to boil milk to sterilize it, but that if kept at a temperature of 167° for twenty minutes this result may be accomplished.—*Medical News*, June 4, 1892.

SURGERY.

By T. W. HUNTINGTON, B. A., M. D., Surgeon Southern Pacific Company's Hospital, Sacramento, Cal.,

J. F. MORSE, M. D., Surgeon German Hospital, San Francisco, Cal., and

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Nephrolithotomy Removal of Calculus Weighing Five Ounces.—DR. GEORGE W. GAY reports the following case: For eleven years patient, aged 43, had suffered from frequent attacks of renal colic. Six months prior to operation a tumor made its appearance in the right side, increasing rapidly in size until it extended from the median line to the ribs above, into the right inguinal region below. It was elastic, uneven, fluctuating, not tender, descended upon full inspiration, and had all the characteristics of a dilated kidney. No hard substance was to be felt. There was a distinct groove between the tumor and the liver. The urine was free, cloudy, specific gravity 1020, sediment copious, ropy, and very tenacious. The patient was etherized and placed upon the left side. An incision, five inches long, was made midway between the ribs and the crest of the ilium, commencing about three inches from the spine and extending toward the median line. The peritoneal cavity was accidentally opened at the most prominent part of the tumor, but was closed after a careful digital examination of the cavity had been made, and no ill results followed. The kidney was exposed, and found to be a large, thin-walled cyst. The stone was readily detected by the finger. On opening the kidney, between one and two pints of a turbid fluid escaped. It was free from any disagreeable odor. The calculus was fixed in one or more of the calyces of the renal cavity, but was dislodged by moderate effort and removed. The cyst, for such the kidney had become by distention and absorption, was thin walled and prone to collapse. No renal structure was visible to the eye or apparent to the touch. It was secured to the posterior angle of the wound with silk. The remainder of the incision was closed by a deep and superficial series of continued sutures. Union in this portion of the wound took place by first intention. Comparatively little shock followed the operation, although there was a good deal of pain. The catheter was used twenty-four hours. The urine was neutral, cloudy, sp. gr. 1018, albumin $\frac{1}{8}$ per cent., sediment abundant, slightly ropy, and contained an occasional granular cast, bladder and renal cells. Two days later micturition was voluntary. Notwithstanding a large opening into and free drainage from the right kidney, very little fluid escaped, probably not over two ounces in the twenty-four hours. At no time were there any symptoms of uremic poisoning. The patient sat up in three to four weeks and went home in six weeks. The calculus was seven inches in circumference and two and three-quarters in diameter. It weighed five ounces when removed and was composed chiefly of phosphate of lime, with a small amount of carbonate of lime and triple phosphate. Five months after the operation, patient was fat and ruddy; the wound had closed to a small sinus; no colic since the operation. Urine much improved; quantity, three quarts in 24 hours. Density, 1.012; alkalines, slight trace of albumin; abundant sediment which contains large numbers of triple phosphates, crystals, some mucus and an occasional pus cell. The principal symptoms of stone in the kidney are, pain, hematuria, pyuria, and tumor. Pain is usually in the region of the organ affected, and may extend to the testicle. Renal colic is more or less frequent and is an important diagnostic feature. Pus and blood are to be found in the urine in the majority of cases, varying as to amount and persistency. Tumor is developed only in the later

stages. The disease is essentially chronic in its character. The operation of nephrolithotomy is not a very dangerous one. In a list of 50 cases, 8 were fatal, and 42 recovered more or less completely. In a list of 68 cases, recorded in English and American literature, from January 1, 1888, to January 1, 1892, in which the kidney was opened and one or more calculi found, 58 recovered and 10 died, a mortality of 14 per cent. In 118 cases reported by Baum (50) and Whitney (68) to April, 1892, 100 patients recovered and 18 died, a mortality of 15 per cent. The noticeable features in these cases were that the number and size of stones varied greatly. The largest calculus weighed five ounces. The largest number found in one kidney was 150. An early diagnosis and an early removal of the stone are the two most important elements in the successful management of calculus in the kidney. If the symptoms of renal colic, together with long continuance of purulent or bloody urine are prominent, persistent, and severe, and if the patient is disabled and rendered unfit to enjoy life by reason of this disturbance, an exploratory operation is to be recommended as being reasonably safe and as offering chances for a more or less permanent relief. The achievements in kidney surgery in many directions have been brilliant. Foreign bodies have been successfully removed, suppurating cavities drained, wandering kidneys brought back to their original home, and useless organs have been removed. As regards calculi, relief must be sought at the hands of the surgeon, even if the results are not always as favorable as could be desired.—*Boston Medical and Surgical Journal*, August 11, 1892.

Subcutaneous Suture of Fractured Patella.—MR. D. W. AIKEN in this operation uses an instrument which is in the shape of a drill, with a tube to carry a stout silver suture. Under chloroform an assistant flexes the knee until the patella becomes most prominent, the muscles are relaxed, and the fragments can be brought close together. The instrument is introduced from below, and the patella is slowly and carefully pierced with the threaded drill, which is finally passed through the skin above. The wire is now seized and drawn out. The end being held, the instrument is withdrawn, while the wire occupies its track, the drill is then reintroduced at the same lower hole, but superficial to the patella—in fact just beneath the skin. When the end points from the same upper hole the wire which was left projecting there, is bent back and pushed into the drill tube and carried down along with the instrument. Both ends of the wire project from the same hole below. The loop above is made to enter the skin, and the ends of the wire are pulled tight until it is felt to close down upon the patella. The advantages claimed are: (1) The great ease of the operation with the instrument described. (2) The fragments are themselves acted upon and united firmly together. (3) No foreign body is left to irritate the joint. (4) It is entirely subcutaneous—that is, if strict antiseptic precautions are taken.—*British Medical Journal*, July 23, 1892.

Treatment of Dislocation of the Clavicle.—DR. H. HAMILTON reports the case of a young lieutenant who sustained a dislocation of the outer end of the clavicle upwards, which was reduced and put up with a pad in the axilla, and an ordinary roller bandage carried round the arm on the injured side, just above the elbow, then around the body, and finally brought up over the injured clavicle, on which a pad was placed. The arm was then put in a sling, and the bones were seen to be in proper place. Not being satisfied with this arrangement, the dressings were removed and a very large pad was placed in the axilla, and a piece of country belting 1½-inch broad, known in India by the name of

"nawar," and very strong, soft, inelastic, and pliable, was passed round the injured arm and body, made to overlap about 3 or 4 inches, and the ends securely stitched together. Another piece was then attached by stitches to this at the back, a little to the left of the middle line, brought firmly up over the displaced clavicle, on which was placed a large pad, and secured to the circular band below by stitches. The pad over the clavicle was secured by a few stitches to the belting. To keep up a gentle downward traction there was attached a short piece of belting with a buckle at the end to the circular band in front and another long piece at the back, both in the depending position. The longer piece was brought forward between the legs and buckled to the shorter piece. A short sling to support the hand and forearm completed the arrangement. The treatment was continued for three weeks, and three months from the date of accident he was able to perform all his military duties. This apparatus secures absolute fixity of the arm and shoulder, the pad in the axilla acts as a fulcrum to draw the acromion outwards, and allows the clavicle to fall into its place, while the clavicular pad and band keep the bone in position; downward traction being maintained by the perineal band. The acromion should be removed as far as possible from the middle line, both in fractures and dislocations, so that the bones, or fragments of bone, may fall into place; nothing is more effective for this purpose than keeping the shoulder depressed. The principle of the treatment by three handkerchiefs, as advocated by Syme, might be easily added to the treatment as above described. A band of belting would be sewn round each shoulder, and to each of these another short piece would be attached horizontally at the back, one of them ending on a buckle. By passing the other through the buckle any amount of force could be applied in drawing the shoulder back.—*British Medical Journal*, July 9, 1892.

Test Tubes For Exploring Wound Cavities.—DR. J. S. FULTON reports a case in which a man, aged 50, fired a 22-calibre bullet into his skull, just above the right ear. Trephining was performed, and the wound cleansed and dressed antiseptically. A tablespoonful or more of brain substance was lost. The bullet was not found. About twelve hours later the patient was turned over on his left side, and a test tube, 3 inches long and $\frac{5}{16}$ of an inch in diameter, was passed into the wound. With the aid of an ophthalmoscope mirror sufficient light was thrown on the spot to show in clear detail all that came in contact with the glass as it sank slowly almost its entire length into the brain. The bullet was not found, however, and the patient died thirty-six hours after receipt of the injury without having recovered consciousness. The advantages of such a mode of exploration are: (1) The instrument is of the ideally aseptic material—glass. (2) While very delicately responsive to the touch, it is easily directed by the sight. (3) It renders possible and justifies the avoidance of prolonged and elaborate search. (4) Instruments may be introduced by the side of the tube, and a bullet, once located, may, with the aid of vision, be seized and withdrawn with less injury to the brain than would be likely to attend any ordinary method of extraction. The disadvantages of the procedure are: (1) The cranial wound may not admit a tube of sufficient size, and there may be reasons against enlarging it. A tube $\frac{3}{16}$ of an inch in diameter will give an aperture adequate for good definition at the bottom of the tube, at the depth of two inches, but little could be seen at the sides. A tube of this size could not, perhaps, be safely introduced through the wound made by a 22-calibre bullet. (2) The method presupposes a straight, or nearly straight, track.—*British Medical Journal*, June 18, 1892.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

By WM. ELLERY BRIGGS, M. D., Sacramento, Cal.

The Prevention of Ophthalmia Neonatorum.—The New York Legislature passed the following act, to take effect on the first day of September, 1890: Sec. 1. Should any midwife or nurse having charge of an infant in this state notice that one or both eyes of such infant are reddened or inflamed at any time within two weeks after its birth, it shall be the duty of such midwife or nurse having charge of such infant, to report the fact in writing within six hours to the health officer or some equally qualified practitioner of medicine of the city, town or district in which the parents of the child reside. Sec. 2. Any failure to comply with the provisions of this act shall be punished by a fine not exceeding one hundred dollars, or imprisonment not exceeding six months, or both. If the provisions of this act are enforced a very marked reduction of the blind will result.—*Boston Medical and Surgical Journal*.

Electro-medical Eye-baths in the Treatment of Scleritis and Episcleritis. DR. JOSEPH NOOSA publishes several cases in which he had favorable results in the treatment of rheumatic forms of scleritis and episcleritis in connection with cocaine and salicylate of lithium, administered with electricity. The catalysis of the galvanic current assists in removing the inflammatory products. The cataphoric action of the electric stream is also had by the aid of a current, 1 to 3 milliamperes in strength being passed through the diseased eye. This is done by placing a common electrode in the region of the cervical sympathetic while the other is connected with an eye-bath filled with a 1 to 2 per cent. solution of salicylate of lithium. The application produces some pain and redness, which subsides within two hours. The sittings should be daily, of five minutes each. Episcleritis was cured in a few weeks, and in spite of exposure had continued well.—*Centralblatt f. praktische Augenheilkunde*.

Brain Abscess Resulting from Suppurative Otitis Media.—A patient, æt. 30, had suffered for a number of years with middle ear inflammation on both sides. During a few days he had also had intense pain on the right side. There was great tenderness over the right mastoid and parietal bone, and paralysis of the right facial nerve. For a few days there had been disturbance of the sensorium, hemiplegia and hemianesthesia on the left side, muscular twitching in right arm and leg. Opening the mastoid temporarily improved the symptoms. Soon after, external strabismus of the right eye appeared. Trephination was, therefore, made at the right of the second temporal convolution. The dura mater was injected, and greatly pressed forward. An incision into the brain gave exit to soft, degenerated brain substance and sero-purulent fluid. No distinct cavity or pus-sac was found. Death followed in eight days. The autopsy revealed extensive necrosis of the right mastoid process, with corresponding circumscribed pachymeningitis, with softening of the whole right cerebral hemisphere, hemorrhage into temporal convolutions, and secondary meningitis.—*Centralblatt f. klin. Medicin*, August 6, 1892.

Sutures of the Cornea.—M. ADAMUCK is of the opinion that corneal sutures are indicated in wounds of that membrane which produce gaping to any marked extent. They may be produced by accidental injuries to the cornea, but more commonly as the result of treatment, keratoglobus and keratoconus. In keratoconus, where the surgeon is obliged to make the corneal wound at the summit of the cone, the corneal sutures render great service. After making a

circular or semi-oval opening through the centre of the cornea, there is no tendency to coaptation or approaching of the corneal wound till the edges are brought together with the sutures. By introducing at two or three points with Richet's needle, healing is greatly hastened. The eye should be carefully bandaged for a few days after the sutures have been removed, which should be on the fourth or fifth day.—*Archives d'Ophthalmologie*, July, 1892.

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

By G. L. SIMMONS, JR., M. D., Sacramento, Cal.

Heat in the Treatment of Syphilis.—AUSSASS (*Jour. des Mal. Cut. et Syph.*) reports the case of a young man aged 17, who had contracted the disease from a wet nurse, and who for two years had suffered from persistent headache, which yielded neither to mercury nor to full doses of the iodide of potash. Daily hot baths, in combination with mercurial inunctions, were ordered, under which marked improvement followed in a short time.—*American Journal of Medical Science*, August, 1892.

Local Treatment of Lupus with Sulphurous Acid.—DR. A. J. HARRISON, of Bristol, in a paper upon this subject, says, in his hands the disease under this treatment became curable. Nine of his cases occurred in females, varying in age from 17 to 61 years, the duration of the disease being from 4 to 40 years. As regards severity, the cases varied in size from a small patch on the cheek ($1\frac{1}{2}$ inches by 1 inch) to involvement of nearly every feature of the face; and in one case, in addition to the face, the whole of the left arm, from 4 inches above the left elbow to the tips of the little and ring fingers. The plan of treatment is based on the powerful properties of nascent bodies. No. 1 or night lotion, an aqueous solution of hyposulphite of soda, gr. 40 to $\mathfrak{z}$ i, is applied to the affected parts by means of lint covered with gutta percha tissue or oilskin, the object being to saturate the tissues thoroughly with the soda salt. The next morning No. 2, or the day lotion, consisting of pure hydrochloric acid, m. v in water $\mathfrak{z}$ i, is applied. In this way, deep down in the diseased structures, a quantity of nascent sulphur and sulphurous acid is formed. The result is that the lupoid tissue is destroyed, and unmistakable evidence of a return to health is soon seen. The lotions are changed night and day, and the only pain or smarting experienced is when No. 2 succeeds No. 1. This treatment must be continued for weeks, and varied in different cases. Scabs and scales quickly disappear, and an ulcerated surface, which soon shows a tendency to heal, appears. Milder measures must succeed, or be used as alternatives. In cases of superficial lupus, where the ulcerative process has not been deep, the application of the following cosmetic paint is found useful: Powdered starch, $\mathfrak{z}$ i; oxide of zinc, $\mathfrak{z}$ i; calamine, $\mathfrak{z}$ iss; glycerine, $\mathfrak{z}$ i; rose or elderflower water, $\mathfrak{z}$ i. This forms a protective coating, and disguises the erythematous condition of the skin. It might be used either alone, or used to succeed the lotions of acid and sulphur. Where the ulcerative process is deeper, he found an ointment more beneficial. Vaseline and lanoline, aa $\mathfrak{z}$ i; spermaceti, $\mathfrak{z}$ ss; ol. eucalyptol, $\mathfrak{z}$ ss; boracic acid, finely powdered, $\mathfrak{z}$ i. Melt and mix ingredients, and scent with oil of cloves or roses. Dr. Harrison, in conclusion, says: (1) That he made no distinction of kind between lupus vulgaris and lupus erythematosus, or if the terms were preferred, between exedens and non-exedens. (2) That lupus depended on a microbe or bacillus not distinguishable microscopically from Koch's bacillus. (3) That lupus had no connection with syphilis, though syphilis might be coincident.—*British Medical Journal*, August, 6, 1892.

Electrical Treatment for Port Wine Stains.—DR. MORTON PRINCE describes his method of treating port wine stains as follows: The needle connected with the positive pole is thrust into the true skin, parallel with the surface, for a distance of one-half to one inch; the skin is threaded or skewered, as it were, by the needle. The negative pole is placed in the hand and the current is turned on gradually until from two to three milliamperes are recorded. It is now necessary to watch with great care the changes in the skin over the needle. The first change to be noticed is that the track of the needle is marked by a sharply-defined white line, the red or purple-colored skin, directly over the needle, becoming blanched by an apparent contraction of the blood-vessels. In the course of a few seconds, little dark spots appear in the white line, soon coalescing, and the track of the needle becomes marked by a black line, due, apparently, to coagulated blood. If the process be continued, the tissue swells, and the epidermis may be raised as a vesicle, and much inflammatory action and necrosis may follow. So, when a number of the black spots along the course of the needle have appeared, the needle should be removed. The process, even then, will continue, and the track of the needle be indicated by a dark brown line. All depends on the electrolytic process being suspended at the right point; otherwise either the results will be insufficient or damage done. The needle should not be inserted again near the same place for two or three weeks, until the healing process is completed. At the end of this time the track of the needle will be marked by a yellowish colored skin. This color fades with time until it approximates that of the normal skin. Great care must be taken in calculating the distance by which these parallel lines should be separated. It should be such as to be a multiple of the width of the resulting white line, otherwise streaks of colored skin will be left between.—*Boston Medical and Surgical Journal*, July 28, 1892.

MATERIA MEDICA AND THERAPEUTICS.

By WM. WATT KERR, M. A., M. B., C. M., Professor of Clinical Medicine, University of California, San Francisco.

The Drugs Employed in the Treatment of Inebriety.—DR. W. F. WAUGH, in an article upon this subject (*Times and Register*), states that "the unquenchable thirst" for alcohol, concerning which we hear so much from the temperance extremists, frequently has its seat in the pharynx, and is catarrhal. Alcohol relieves the burning and dryness; and in a few cases it has been found that gargling with it affords as much relief as swallowing the beverage. For such cases, coca is well suited. It relieves the symptoms as speedily and more permanently than alcohol. For the convenience of these persons I have had coca leaves made into a plug, like tobacco, which can be carried in the pocket and taken without exciting notice. The indescribable gnawing at the stomach, the hypochondriacal and melancholic sensations following the cessation of alcohol are dissipated by coca as by no other remedy. *Strychnine*.—The function of strychnine is to relieve the relaxation that follows the withdrawal of stimulants. This relaxation is one of the greatest difficulties in the way of cure. Strychnine keys up the nerves and muscles. It removes the depressed state that makes one wish for alcohol. To produce this effect requires far more than the ordinary doses of strychnine. A twentieth of a grain every two hours, increased to double the dose if necessary, is likely to be required. The effects, however, must be watched. *Brucine* possesses properties similar to those of strychnine, and in some cases it seems to be better borne, safer and more permanent in its effects. *Atropine*.—The cerebral fullness which follows the use

of alcohol may be imitated by the use of nitro-glycerine, or of atropine. The latter is preferable, as its effects are not so evanescent. It is easy enough to fill a man's brain so full of blood by a toxic dose of atropine that the idea of alcohol is disagreeable to him. *Capsicum*.—This, the chief remedy in acute alcoholism, is also essential to the treatment of the chronic form. No other remedy so certainly stimulates the digestive organs. Without it the patient digests little or nothing, and the resulting debility impels him to resume the alcohol. The amount of capsicum to be given varies greatly; but in general, from 2 to 10 grains at each meal is sufficient. *Chloride of Ammonium* does for the liver what capsicum does for the stomach. It supplies the stimulus that the organ has become accustomed to receive from alcohol, it lessens the hyperemic condition, and, while it cannot build up new hepatic cells to replace those that have been destroyed, it gets from those that remain all of which they are capable. *Arsenic*.—The function of this drug is the relief of gastric symptoms; the nausea, vomiting, pyrosis, gastralgia, and other symptoms of catarrh. This is a remedy for the period following the cure, when atropine and capsicum are no longer required. *Hyoscine* is of value in the rare cases where insomnia persists, and does not yield to hygienic measures. The best remedy for insomnia is a bowl of hot milk, with clam juice and capsicum, taken at bed time. Many other remedies are of value in the treatment of individual cases. It will be seen that nothing is said of gold. The ground is so fully covered that there is nothing left for this alleged remedy to perform. It may assist atropine in causing cerebral congestion, or chloride of ammonium in lessening hepatic hyperemia, or it may act as a temporary stimulant. But the effect of gold as promoting defective tissue metamorphosis renders it unsuitable for any but temporary use in these cases.

Therapeutic Use of the Salts of Strontium.—As the salts of strontium have been found to be diuretic when given to dogs, it was expected that they would behave in the same manner in man. On testing them, however, PROF. SÉE found that diuresis could not be produced by their means, even in cases in which it was easily set up in other ways. It was noticed however, that in patients with Bright's disease or heart affection, the digestive troubles underwent a very marked improvement. This led the author to try the effect of bromide of strontium in gastric affections. Thirty-two patients, mostly suffering from acid dyspepsia, with or without dilatation of the stomach, were thus tested, the minimum daily dose being 30 grains, and the maximum a drachm, taken between meals. All showed marked improvement; the diminution of gas formation was very noteworthy. DUJARDIN-BEAUMETZ makes the following statement as to the clinical uses of the salts of strontium. The only salt of which he had had any experience was the lactate. This he had employed in a number of cases of Bright's disease, with albuminuria; under its influence the albumin diminished very considerably, in some cases being reduced one-half. He attributed this favorable action rather to the very beneficial action on digestion than to their direct action on the kidneys.—*Boston Medical and Surgical Journal*.

MEDICINE AND PATHOLOGY.

By ALBERT ABRAMS, M. D., Demonstrator of Pathology, and Adjunct to the Chair of Clinical Medicine, Cooper Medical College, San Francisco, Cal.

Chorea.—DRS. WALTON and VICKERY have studied this affection with special reference to its connection with rheumatism and heart disease. The conclusions formulated are based on the careful analysis of 76 cases of chorea observed

by the authors: (1) Neither rheumatism nor heart disease is essential to chorea. (2) The preponderance of evidence points toward the conclusion, not only that rheumatism and organic heart disease conjointly appear more frequently in the choreic subject than can be accounted for by coincidence, but that the same is true of each of these affections separately. It follows, therefore, that (a) rheumatism predisposes to chorea, and (b) organic heart disease has the same tendency. (3) Drawn from the observations of others, fatal cases are generally associated with organic heart disease, and probably with organic disease of the central nervous system, notably cerebral emboli. (4) There is a large class of functional cases—largely reflex, and fostered by circumstances tending to produce functional symptoms in general. (5) The pathological connection between rheumatism and chorea, excepting in the cases where emboli are produced by accompanying endocarditis, is still obscure; probably no one theory is applicable to all cases. (6) The mechanism by which the peculiar phenomena of chorea are produced is unknown.—*American Journal of Medical Sciences*, May, 1892.

The Nature of Fish Poison.—ARNSTAMOFF (*Centralblatt f. Bakteriologie u. parasiten*) observed 11 cases of poisoning in human beings after partaking of salted salmon; in 5 of which death occurred. An examination of the fish showed a peculiar soft consistency, but no putrefaction. Under the microscope a large number of living microorganisms were seen, which bore considerable resemblance to the typhoid bacilli. Symptoms of poisoning developed in the patients in 10 to 28 hours after ingestion of the fish; the amount ingested had no influence on the rapidity and intensity of the toxic symptoms. The chief manifestations consisted of general weakness, abdominal pains, dyspnea, mydriasis, diplopia, vertigo, dryness in the mouth, dysphagia, aphonia, obstipation, anuria, and reduction of temperature. The pathologico-anatomical examination showed nothing specific other than death from asphyxia. The microscopical and bacteriological examination of the organs demonstrated the presence of microbes similar to those found in the fish. Pure cultures made with these microbes were injected into 19 rabbits, 2 dogs and 2 cats. All the rabbits died, and the dogs and cats recovered, but only after severe illness. The animals showed symptoms similar to those observed in the human being, and in the viscera of those examined *post-mortem* the same specific microorganisms were found.—*Centralblatt f. klin. Medicin*, March 19, 1892.

The Value of Albuminuria as a Means of Diagnosis.—The question of albuminuria has, DR. F. R. STURGIS says, two views, or rather two theories, are held regarding it: (1) That albumin may be present in small quantities in the urine in a condition of perfect health. (2) That the presence of albumin in the urine is always indicative of disease. In 1865, Gubler suggested that albumin was present in the urine of healthy persons; in 1870, Ultzmann found albumin in 8 young persons who were in good health; and in 1873, Vogel stated that he had recognized that albumin might exist without appreciable lesion of any organ. Senator is also credited with the statement that many cases of albuminuria are found in perfect health. Dickinson has tested the urine for albumin in 100 cases, by several methods. Of these 100 cases all the tests showed albumin in every case of disease of the kidneys, intermittent hematuria, fluid in the pleura, measles, diarrhea and peritonitis. Throwing out the 19 cases of renal disease, 81 remain; of these 20 cases show albumin when tested by heat and nitric acid, 35 when tested by picric acid, 22 when tested by ferro-cyanide of potassium and citric

acid, and 26 when tested by acidulated brine solution. But every case, 81 in all, when tested by the double iodides of mercury and potassium show albuminuria, a proportion so large as to cause doubt about the accuracy of this test. Dr. Sandy's cases, 140 in number, showed no albumin in 40 patients, while in 105 the urine was albuminous. Of these latter, 64 cases were attributed to renal disease and 81 were non-renal cases; 41 showed albumin in the urine, and these 41 occurred in cases of dyspepsia, debility, phthisis and morbus cordis. Life insurance cases showed a great difference again in the number of albuminous subjects. Dr. Mahomed found albuminuria present in 15.5 per cent., and Dr. Mann in 11 per cent. of the cases which were presented for life insurance. The foregoing figures show how widely results vary as to the significance of albumin in the urine and the number of cases in which it is found, no two of the tests agreeing with anything like unanimity. Indeed, one of them is open to suspicion from the very large proportion in which albumin occurs in the urine of so-called healthy subjects. Among the tests used were the following: Nitric acid, heat, picric acid, Tunsgate of sodium solution, and the double iodides of mercury and potassium. Dickinson's tables show that in 100 cases the largest proportion of positive results came from the use of the double iodides; every case tested showing albumin. The next largest proportion occurs when picric acid is used, and then when acidulated brine was employed, then ferro-cyanide, and last the heat and nitric acid. From this it is evident that the various tests suggested for albumin are defective. Roberts claims that heat and nitric acid are the safest test, while Dickinson claims that picric acid is the best test, for although it precipitates peptones, and this precipitation cannot be distinguished from albumin at first sight, yet upon boiling the specimen if the precipitate be due to peptones, it is dissolved, whereas if albumin be present, boiling has no effect. Sturgis believes that the decided difference in results obtained by various observers is due mainly to errors in observation. He refers to a substance discovered in 1879 by Dr. Greene, of England, to which the name of "leth-albumen" was given. "Leth-albumen" is a constituent of healthy urine and is allied to albumin. It is diminished in chronic Bright's disease, but not in the acute form. The following inferences are drawn: (1) That albumin in the urine does not necessarily signify any renal disease. (2) That it exists quite frequently in a temporary form in many diseases unassociated with any organic renal complication. (3) That from the uncertainty in the method of testing, and of the various tests now used for its detection, it loses a great deal of its value as a means of diagnosis. (4) When present, no matter if it be in small quantity, it is always a danger signal, and, when persistent, indicates some serious organic lesion.—*International Medical Magazine*, March, 1892.

Lavage of the Stomach in Chlorosis.—PICK (*Wiener klin. Woch.*, No. 50), has occupied himself with the question, To what extent the predominating gastric disturbances in many cases of chlorosis influence the condition of the blood? His results, although not positive in this direction, are of great practical value in demonstrating how, in these cases, washing of the stomach is attended by a rapid disappearance of the chlorotic symptoms. In a certain number of cases previous treatment with iron preparations was without effect. The chief result achieved by washing of the stomach is to check fermentation, or remove the products of fermentation, the absorption of which vitiate the blood. In those cases where washing of the stomach cannot be pursued, the administration of creasote may accomplish the same purpose.—*Berliner klin. Wochenschrift*.

The "Bonuzzi" Method in the Treatment of Tabes.—PROF. BENEDIKT recommends the treatment of tabes as suggested by Dr. Pietro Bonuzzi, for the following reasons: No apparatus is required, and that when compared to the suspension treatment the therapeutic action is decidedly more energetic. Bonuzzi's treatment is carried out as follows: The patient lies on his back, with the head elevated, then the legs are grasped at the ankles and drawn toward the head. This process is gradually carried out until the knees can be brought in contact with the forehead. The mechanical effect on the spinal cord is three times as great by this method as by suspension. The results achieved with tabetics in this treatment are alluded to by Benedikt as wonderful; gait was improved, pains disappeared, and the ataxia was benefited. He recommends this method as an excellent substitute for the suspension treatment in locomotive ataxia.—*Wiener medicin. Presse.*

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. HOISHOLT, M. D., Assistant Physician, State Asylum for Insane, Stockton, Cal.

Inequality of Pupils in Epileptics.—Cases of epilepsy have long been known to occur in which the pupils are found to be of unequal size (anisocoria); the symptom having been considered of diagnostic value in the nocturnal form of epilepsy. In a recent publication, DR. BROWNING reports having found unequal pupils in 16 out of 150 cases of epilepsy. He distinguishes three types of the affection: (1) cases in which the inequality is great; (2) slight but fairly constant difference in size; (3) latent anisocoria—*i. e.*, inequality only distinct on faint illumination. Three of his cases were of the first type; two of these were syphilitic; the third was traumatic epilepsy, for which reason the anisocoria is regarded as being a focal symptom. In the ten cases where there was a slight but fairly constant difference in the size of the pupil, the constancy of the condition rather precludes the possibility of its being a parietic symptom due to exhaustion following epileptic attacks. The latent anisocoria observed by Browning was first found in non-epileptics, in whom it was more frequently met with. He suggests that it indicates disproportionate innervation of the iris by the sympathetic, which only becomes manifested when the action of the oculomotor is relatively or wholly suspended.—*British Medical Journal.*

Hereditary Chorea.—DR. H. SCHLESINGER gives the history of three families, observed in Vienna, in which hereditary chorea occurred. In one family a woman, aged 38, had suffered from the movements for three years. She was partially demented; her father had suffered from a similar condition for some years before his death; she could give no particulars as to her mother and four sisters, who were all dead. In the second family, a man and his sister both suffered from chorea, the former dying after seven years. This man had four sons and three daughters; three sons and one daughter suffered from chorea when adults; and the two eldest sons died at the ages of 37 and 35, respectively. The other son, who began to suffer at the age of 48, and was the patient seen by Schlesinger, had six children, of whom one had epilepsy. The sister had two adult sons who were healthy. In the third family the history was traced for four generations. The earliest case traced was a man who became choreic at the age of 70; his son (a man of 78), and his son's wife are both living and healthy. This couple had three sons and two daughters. The eldest son died of progressive paralysis at 50; the second at 52 of chorea, which began at 49;

the third is healthy at the age of 52, and has two healthy children. The eldest daughter, aged 49, is very hysterical; she has two children, a son aged 24, who has had chorea for eleven years, and a daughter, aged 22, who suffers from melancholia. The second daughter, aged 48, is very hysterical; she has five children, of whom three, whose ages range from 18 to 23, are healthy. Her eldest son, aged 30, has had chorea for eighteen years, and her eldest daughter, aged 25, for twelve years. The author says, in conclusion, that though the symptoms appear as a rule at an advanced period of life, some members of the affected families may begin to suffer at an early age. The rule is, each generation presents cases; but occasionally a generation is skipped. Sometimes the chorea is in one generation replaced by grave hysteria. He believes the disease is progressive, and uninfluenced by arsenic.—*Zeitschr. f. klin. Med.*—*British Medical Journal*.

Polyuria in a Hydrocephalic Imbecile.—WIEDMEISTER has recently had under care an excitable imbecile woman, aged 34, markedly hydrocephalic and hypermetropic, with slight convergent strabismus. Her history showed that polyuria commenced suddenly in the early part of 1890. During the day on which she was admitted into the hospital (August, 1891), she voided 6000 c.cm. of fetid, ammoniacal urine of a sp. gr. of 1003; she micturated about 110 times in the 24 hours. The condition was presumed to be due to involvement of the fourth ventricle by the encephalic dropsy. Treatment failed until a faradic bath of three minutes duration was administered three times weekly. It was soon noticed that after each bath the quantity of urine and frequency of micturition were much diminished. By degrees the urine became clear, acid, sp. gr. 1032, and the amount excreted in 24 hours fell to about 500 c.cm., the number of micturitions becoming normal. Uric acid was in excess, but there was a notable deficiency of urea. The hypermetropia also became much diminished.—*Neurologisches Centralblatt*—*British Medical Journal*.

Treatment of Psychosis following Influenza.—DR. JULIUS ALTHAUS publishes the following results of his experience in these cases. The best rule for treatment is to individualize as much as possible, and treat the patient rather than the disease. A nourishing and easily digestible diet is, in all cases, of the greatest importance. While stimulants of any kind are apt to do harm in general paralysis, a moderate amount of alcoholic stimulant is useful in most cases where there is loss of appetite and physical debility in addition to mental perversion; they are especially required in the delirium of inanition. Rest, avoidance of excitement, and change of air and scene, are among our best restoratives where the normal functions of the brain have been impaired. Where the patient is excited and hallucinatory, as in the delirium of inanition, subcutaneous injections of morphine and atropine may be used with considerable advantage. Insomnia is best overcome by prolonged warm baths, and, if necessary, by the use of sulphonal and paraldehyde; anorexia, by bitter tonics; general debility, by quinine, strychnine, and phosphorus. Where the pulse is feeble and rapid, indicating cardiac debility, digitalis and strophanthus should be administered. Alteratives and aperients must be given where the action of the liver and bowels is irregular. He finally recommends a judicious application of the constant galvanic current to improve the tone of the nervous system; it is applied more particularly to the pre-frontal lobes and the medulla oblongata, in doses of one-half to two milliamperes, for between five and ten minutes, either daily or every other day.—*American Journal of Medical Sciences*.

Mutilation of an Unborn Child by its Mother.—A singular case of mutilation during childbirth recently occurred in England. An unmarried woman, traveling alone in a railway compartment, was seized with labor pains and found an arm protruding from the vagina. In her efforts to deliver herself she broke the arm and afterwards cut it off with a table-knife she had with her. When, about an hour afterwards, she was delivered by turning, the child was found almost entirely exsanguinated from the hemorrhage through the brachial artery, the arm having been cut off about two inches above the elbow. The medico-legal aspect of the case is most interesting. The mother having mutilated the child while it was still unborn, and therefore a part of herself, she is exempted from criminality in an act that an hour later would have been murder, or at the time it occurred would have been murder had it been done by any one beside the mother herself.—*Northwestern Lancet*, April 1, 1892.

Hypertrichiasis and Mental Derangement.—DR. ANDREA CRISTANI, in a paper on this subject (*Archivio di Psichiatria*), gives the results of his investigation in 272 cases of insanity in females, and a similar number of sane women, with reference to the development of hair in various parts of the body, in which it is not found under ordinary circumstances. The insane ranged in age from 20 to 80 years, while the sane were all over 65. He found that hypertrichiasis in the face, as well as elsewhere, is present much oftener amongst the insane than among the sane; that it is associated with signs of degeneration, and that it is more frequently present amongst insane patients in whom other signs of degeneration are present than among those who do not show degenerative symptoms. He also finds that the hairs are thicker and stiffer, and closely resemble those of the inferior races.—*Lancet*, April 30, 1892.

FORMULÆ.

By GEO. B. SOMERS, M. D., San Francisco, Cal.

Excoriations in Infants.—DR. FLOYD M. CRANDALL, in an interesting article on the management of the new-born infant, states that he has obtained better results from an oily preparation than from powders, where excoriations are severe. He recommends the following, proposed by Fox:

Acid salicylici.....gr. x
Bismuthi subnit.....3 ii
Amyli.....3 iss
Ung. aq. rosa ad.....3 i

—*New York Medical Journal*.

Dipsomania.—ALEXANDER gives the following as a good remedy to enable drunkards to resist the drink crave:

Tinct. capsici.....m. x
Sodii bromidi.....gr. x
Spirits ammoniæ.....3 i

S.—Give at a dose several times daily.—*New York Medical Journal*.

Ozena.—SCHNITZLER advises:

Powd. benzoate of soda
Iodoform.....āā 3 iii
Tar.....gtt v—M.

S.—For insufflations against ozena.

The following powder may be used for the same purpose:

Iodoform (powdered)
Burnt coffee finely powdered.....āā 3 iii

Mix with care.—*Union Médicale*.

Antiseptic Mouth Wash.—MULLER advises:

Acid thymic.....gr. iv
Acid benzoic.....3 ii
Tinct. eucalypti.....3 ss
Spt. vini. rect.....3 iii
Ess. menth. pip.....gtt. x

S.—Drop enough into a glass of water to cause turbidity, and rinse the mouth morning and night.—*Medical Record*.

Caustic Treatment of Cancer.—DR. DANIEL LEWIS quotes the following mixtures for use in cases where an operation cannot be performed:

I. Jennings's Formula:

Hydrochlorate of cocaine 3 ss
Caustic potash 3 iss
Vaseline 3 ii—M.

S.—Rub in small portions with a wooden spatula. Wipe away charred portions, in order to prevent destruction of healthy tissue.

II. Marsden's Formula:

Arsenious paste 2 parts
Mucilage of acacia 1 part
Mix into a paste too thick to run.

S.—Apply to only one square inch of the ulcer.

III. Bougard's Paste:

Wheat flour gm. 60
Starch gm. 60
Arsenic gm. 1
Cinnabar gm. 5
Sal ammonia gm. 5
Corrosive sublimate cgm. 0.50
Sublimate of chloride of zinc [at 52°] gm. 24.5

The first six sublimates are separately ground and reduced to a fine powder. Then add the chloride of zinc solution slowly, with stirring to prevent lumps.

S.—A thick layer is spread on cotton and left in position for 24 hours.—*Medical Record*.

Chorea with Valvular Heart Disease.—DA COSTA recommends:

Tinct. belladonnæ 3 i
Liq. potassii arsenitis 3 ii
Syr. hypophos. comp. ad 3 iii

S.—Teaspoonful to be taken three times daily.—*Medical News*.

Resolvent Glycerite.—

Iodoform 3 ss
Balsam Peru 3 ii
Glycerine ad 3 i—M.

S.—For inunctions against strumous swellings—cod-liver oil internally. Tonic alimentation.—*Union Médicale*.

Liniment for Gout.—In his small work on rheumatism and gout, SATTERLEE recommends the following local application:

Ol. gaultheriæ
Ol. olivæ
Lin. saponis
Tr. aconiti
Tr. opii āā 3 ii—M.

S.—Apply freely and cover with cotton batting.—*Med. Sum.*—*Canada Med. Record*.

Spiritus Ophthalmicus.—This is an old English remedy for conjunctivitis. WITTENDÖRF, of New York, has done more than any one else to popularize it in this country:

Spiritus camphoræ
Spiritus vini Gallici āā 3 i
Spiritus lavandulæ
Spiritus rosmarini āā 3 ii—M.

S.—Eye spirits—to be used only externally over the closed eyelids.—*Post-Graduate*.

Chapped Hands.—STEFFEN recommends:

Menthol gr. xx
Salol 3 ss
Olive oil 3 ss
Lanoline 3 iss—M.

S.—Use twice a day. The pain ceases, the skin becomes soft and the cracks disappear.—*Union Médicale*.

Condurango as a Stomachic.—KRAUS gives:

Fluid ext. condurango 3 ss
Hydrate of chloral gr. x
Syrup of orange 3 v
Distilled water 3 iv

S.—Three or four tablespoonsful during the day.—*Terapia Moderna*—*Médecine Moderne*.

Saponified Dental Powder.—LASAR advises:

Precipitated carbonate of calcium 3 iii
Chlorate of potash
Pulverized pumice stone
..... āā 3 ss
Medicinal soap 3 vi
Essence of peppermint m xv
—*Nouveaux Remèdes*.

PUBLIC HEALTH.

By W. R. CLUNESS, M.A., M.D., Sacramento, Cal.

Mortality for July.—The deaths registered in 98 town districts of the State during the month of July, in a population of 783,300, correspond to an annual rate of 16.68 a thousand, the total mortality having been 1,091. 169 deaths were due to zymotic diseases, giving an annual rate of 2.52 a thousand. Of these, 20 were due to diphtheria, 53 to cholera infantum, 28 to typhoid fever, 24 to diarrhea and dysentery, 6 to cerebro spinal fever, 9 to scarlet fever, 16 to whooping cough, 5 to croup, 1 to measles, and 7 to remittent and intermittent fever. 215 deaths were due to diseases of the respiratory organs, giving an annual rate of 3.36 a thousand. Of these, 129 were due to consumption, 47 to pneumonia, 26 to bronchitis and 13 to pulmonary congestion, the rate being for consumption and pneumonia, respectively, 1.96 and .72. 79 deaths were due to diseases of the heart. The average annual death rate from all causes, occurring in the ten largest cities and towns in the State, and representing a population of 561,800, was 18.12 a thousand. The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants was reported from San Francisco, the lowest from San Diego.

The Progress of Cholera.—The rapid march of cholera westward continues to be the important sanitary question of the day. On July 30th, it is said to have broken out in two localities in Austrian Galicia, and on the same date 9 cases occurred near Presburg, a populous centre a few miles east of Vienna, on the Hungarian border. August 2d, it was again reported at Moscow. August 4th, Austria quarantined for a week all vessels arriving from Turkish ports on the Black Sea. On the same day there occurred 1150 new cases and 550 deaths in the Rostoff and Nakhetcheu districts alone. Official returns also showed that 22 deaths occurred from cholera in Paris, and 11 in the suburbs during the week. Choleraic diarrhea was also prevalent, especially in Argentueil, and amongst those employed in the lime quarries. August 6th, 6,741 new cases and 3,496 deaths occurred from it in all of Russia. August 7th, the Government of Moscow issued a proclamation ordering all possible precautions to be taken to prevent its spread, and fixed severe penalties for non-compliance. August 8th and 9th, there were fewer cases, but on the 10th it was again reported as spreading rapidly in Teheran, and on that day 4,261 cases occurred in Russia, with 2,117 deaths. Again there appeared to have been a temporary cessation, but on the 14th there was a large increase in the number of deaths, 9,417 cases having been reported, and 5,509 deaths. On the same day it raged with great severity in Teheran, the Governor and all wealthy persons having fled. Following its usual custom, there appeared a partial respite from its ravages in Russia, but on the 20th, the official cholera report showed 6,903 new cases, with 2,378 deaths, and on the 21st, 6,784 new cases and 2,786 deaths. On the 22d, 800 died in Teheran alone, the "fatalistic tendencies of the people making it almost impossible to combat the disease," while in all Russia but 3,318 new cases occurred, and 3,429 on the following day. At this date, in consequence of reports that cholera had appeared among Russian emigrants at Stettin, Germany, the American Consul, Edwards, made an inspection of the port and closely scrutinized the condition of the emigrants, but found no cases. On the following day, however, August 23d, 120 cases, with many deaths, occurred at Hamburg, and the facts were duly reported to the State Department at Washington. The same

day 5,505 new cases occurred in Russia, with 2,859 deaths. The evidence now at hand indicates unmistakably that cholera has existed in Hamburg since August 18th, and probably since the 10th, and that it was kept secret until its presence in all parts of the city forced the authorities to acknowledge its existence. An official report from Havre to the authorities in Paris announces its presence in that city on the 24th; also a case at Berlin. The authorities at Washington, however, report the receipt of more reassuring information from Havre, and that after a full examination medical experts deny that the form of the disease prevailing is Asiatic cholera, although they admit the prevalence of "local cholera," whatever that may be. August 26th, cholera is said to have broken out in England, and there can no longer be any doubt that it will sweep Europe to the sea.

Prospects for Cholera in the United States.—There is scarcely a shadow of hope that it can be prevented from reaching New York or Montreal in the near future, and once in either city, it will spread in all directions almost as rapidly as in any European country, for there is poverty and filth everywhere in abundance, and these are its favorite breeding places. The famine in Russia rendered its inhabitants peculiarly susceptible to epidemic influence, and so weakened and reduced their systems as to render them less able to resist disease when attacked. The almost universal prevalence of influenza during the past three years, has also predisposed the people of all nations to cholera, and rendered them more liable to succumb to its baneful influences. With the Atlantic ocean as a barrier, it may be that America will be spared from a visitation, but it does not appear probable. With the return of tourists and the ingress of immigrants, it is scarcely possible that an epidemic disease, so subtle in its habits, can long be kept at bay. The authorities everywhere appear to realize the gravity of the situation, and are preparing to put forth their best efforts to prevent the introduction of the germ; but, as this seems almost impossible, every individual should constitute himself a committee of one, and should see that all sewers in his vicinity, all cess-pools, privies, low lots, damp and illy-ventilated cellars are cleansed and rendered as clean and free from filth as possible. Excesses of all sorts, especially the excessive use of alcoholic liquors, should be avoided; our stomachs should be maintained in as healthy a condition as possible, of acid reaction; water should not be drunk until it has first been thoroughly boiled, and it should be recollected that all evidence goes to show that the germ must be swallowed, and must reach the intestines, before it can produce the characteristic evidences of the disease.

METEOROLOGY.

By J. W. ROBERTSON, B.A., M.D., San Francisco, Cal.

Summary for July.—*Temperature.*—Extremely high temperatures were noted at many of the valley stations, several registering a maximum temperature of over 100°. But the mean temperature did not exceed 80°, while along the coast it was below 60°. This varies but slightly from the normal July.

Rainfall.—No measurable fall occurred during the month. From only three stations was a trace reported.

California—Tabular Statement for July, 1892.

STATIONS.	TEMPERATURE.						RAINFALL.		Mean Relative Hu- midity	WEATHER.			WIND.	FURNISHED BY—
	Mean.....	Highest	Lowest.....	Mean High- est	Mean Low- est	Mean Daily Range	No of Days Rain Fell.....	Total Rain- fall.....		No. of Clear Days.....	No. of Fair Days.....	No. of Cloudy Days.....		
Auburn	75 6	96.0	60.0	69.9	53 1	16.8	1	0.00	79.6	14	1	16	S.	Southern Pacific Company.
Berkeley.....	59 3	91.9	49.0				0	0.01					S.W.	Obs. University of California.
Colfax.....	72.2	99 0	53.0				0	0.00					S.W.	Southern Pacific Company.
Eureka.....	55.4	64.0	46.0	60.1	50.6	9.5	0	0.00	91.4	10	13	8	N.W.	Weather Bureau Dept. Agr.
Fresno.....	79.3	110.0	55.0	97.3	61.4	35.9	0	0.00	32.8	31	0	0	N.W.	"
Keeler.	80.6	100.0	62.0	93.4	67.7	25.7	0	0.00	22.4	29	0	2	S.W.	"
Los Angeles....	68.0	90.0	50.0	80.1	55.9	24.2	0	0.00	76 0	9	22	0	W.	"
Monterey	64.3	86 0	52.0				0	0.00					S.	Southern Pacific Company.
Napa.....	66.0	98.0	49 0	77 9	54.1	23.8	0	0.00	67.3	22	8	1	S.	Station Napa Insane Asylum.
Oakland	59.1	89 0	48.0	74.4	53.4	21.0	0	T.	83.3	17	10	4	W.	Chabot Observatory.
Paso Robles....	73.1	104.0	53.0				0	0.00					N.	Southern Pacific Company.
Red Bluff.....	79.0	105.0	56.0	94.1	63.7	30.4	0	T.	38.7	31	0	0	S.W.	Weather Bureau Dept. Agr.
Sacramento. ...	72.0	102.0	50 0	88.0	55.9	32 1	0	0.00	59.2	29	2	0	S.W.	"
San Bernardino														A. K. Johnson, M. D.
San Diego.....	64.9	75.0	57.0	70.3	59 5	10.8	0	0.00	80 1	18	13	0	W.	Weather Bureau Dept. Agr.
San Francisco..	58.0	90.0	50 0	64.2	52.0	12 3	0	0.00	82.1	18	3	5	W.	"
Santa Barbara..	63 5	81.5	53.0	71.5	55.5	16.0	0	0.00	77.0	20	9	2	E.&S.E.	Hugh D. Vail.
Santa Cruz.....	63.3	95 0	50.0				0	0.00					W.	W. R. Springer.
Yuma.....A. T.	90.0	112 0	66.0	106.0	74.9	31.1	0	0.00		28	3	0	S.W.	Weather Bureau Dept. Agr.

Blank (---) indicates data missing.

Occidental Medical Times

COMMUNICATIONS are invited from all parts of the world. When necessary to elucidate the text, illustrations will be furnished without cost to the author.

SACRAMENTO: SEPTEMBER, 1892.

THE SAN FRANCISCO COUNTY MEDICAL SOCIETY AND ITS RECALCITRANT MEMBERS.

At the regular meeting of the San Francisco County Medical Society, held August 9, 1892, the Committee on Ethics reported on charges of unprofessional conduct, preferred by DR. JOHN C. SUNDBERG, against four members of the Society. The charges specified that quackish methods of advertising had been resorted to by DR. CHARLES H. CLINTON and DR. G. W. DAYWALT in the San Francisco *Daily Report*, of April 30, 1892; also by DR. S. F. LONG and DR. J. P. LEFEVRE, in the San Francisco *Examiner* of June 5th, the *Journal of Commerce* of June 7th, and the *Daily Report* of June 18th, 1892. DR. LONG and DR. LEFEVRE were further charged with using a secret remedy, "Neuro-Tecton."

The Committee on Ethics, consisting of J. A. SIMON, F. Z. BAZAN, H. W. YEMANS, J. T. McDONALD and F. W. D'EVELYN, reported that they had made an investigation, and found the parties guilty as charged. On the other hand, the accused had all expressed regret for the publications, and stated that had proofs of the articles been presented to them for revision they would not have allowed them to appear in their published form. The committee, in view of all the circumstances, decided that a lenient course was best, and recommended that DR. DAYWALT be suspended for thirty days, and that DRs. CLINTON, LONG and LEFEVRE be suspended for the period of ninety days. The report and recommendations were adopted after a brief discussion.

We believe that this action was sufficient in the premises, and that the dignity of the Society will be maintained in the lenient course that it has pursued. Medical societies are organized for bringing the profession in closer relationship, and not for disruption. In questions of this character the Society's action should be reformatory rather than punitive, and error is always best on the side of mercy. We trust that the members will appreciate the liberal spirit that has actuated the Society, and at the same time realize the extreme folly as well as the disastrous pro-

fessional consequences that inevitably follow the adoption of the methods of the charlatan and the impostor. DR. SUNDBERG deserves every credit and commendation in the very unpleasant duty he was compelled to assume.

NOTES.

The San Francisco Therapeutical Society.

This society was organized in San Francisco, July 23, 1892. The following were elected officers: President, F. A. A. Belinge; Vice-President, J. W. Blake; Treasurer, J. R. Davidson; Secretary, M. Neumann. The Society will meet twice each month.

A Large Sized Brain.

On July 31, 1892, at San Francisco, George H. Maynard, aged 26, was struck on the head with the butt end of a pistol. He died about twelve hours after the blow. A *post-mortem* examination showed two scalp wounds in the occipital region, but no fracture. The brain showed considerable congestion. Eight ounces of blood were found between the brain and meninges, and three ounces of serum in the cavity of the skull. All the other organs were healthy. The interesting feature of the case was the weight of the brain, which was 64 ounces. On inquiry those who were present at the autopsy stated that before weighing, the size of the brain did not strike them as being extraordinary. The average brain weighs from 48 to 50 ozs. The weight of Cuvier's brain was 64 ozs., which Maynard's therefore equals. Dr. Abercrombie's brain weighed 63 ozs., and even these extreme weights have no doubt often been exceeded. In another column, Dr. W. J. G. Dawson, of St. Helena, gives some interesting figures in relation to excessive brain weight.

San Francisco's New Receiving Hospital.

The new Receiving Hospital, situated in the new City Hall, was occupied by the Police Surgeon and staff, on August 22. Within an hour after removing the instruments from the old building on Kearny and Washington streets, business was resumed at the new. The present quarters have been newly furnished throughout, and very little of the old furniture had to be used. The place was fitted up by the City Hall Commissioners according to plans agreed upon by the Board of Health and Police Surgeon. The result is something that the citizens of San Francisco may well be proud of. The city has hitherto labored under the stigma of tolerating an emergency hospital in quarters entirely unsuitable for the purpose, as the place was badly lighted, badly ventilated, and badly equipped. But all this is now changed. The accommodations and equipments of the new hospital are admirable in every particular. Facilities are provided for aseptic surgery; there are separate

male and female wards, and a ward for the special care of violent or insane cases. Other features worth mentioning are the system of electric lighting, the cement floors covered with rubber matting, and the apparatus for heating. With such accommodations, and provided the city authorities continue to support it properly, the future reputation of the hospital rests entirely in the hands of those having charge of it.

Look Out for "Dr." Welch.

Some three months ago a person calling himself "Dr. J. S. Welch" appeared at Butte City, Montana, with a letter of introduction to one of the leading physicians from an old friend in a neighboring town. The visitor had been unfortunate, and the physician, taking pity on him, advanced him money, gave him the use of a room in his office, and turned over to his care several cases. The stranger stated that he was a graduate of Jefferson, also that he was an army surgeon, and again that he was visiting Montana for his health, though subsequent developments would imply that he was not there altogether for that purpose. He proved to be a very good talker and a very smooth individual generally. He "worked" the town and a great many persons, and finally ingratiated himself into the confidence of a lady resident to such an extent as to obtain possession of a valuable diamond ring. This he disposed of for \$75 and shortly after left there for parts unknown. His benefactor, the physician, loses about \$100 in cash and instruments, the latter being of no use to the rascal except for the purpose of deceiving others, or to sell. A gentleman has since stated that Welch obtained his medical education and diploma while in the army and acting as a nurse at Fort Keogh. His memory was excellent, his knowledge of technical terms, etc., was very good, and he contrived to completely deceive the man who befriended him. Welch is supposed to have gone to Salt Lake City, and as he may possibly travel westward, this is published as a warning to a generous and sympathetic profession.

SOCIETY PROCEEDINGS.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Regular Meeting, July 26, 1892.

The President, G. C. SIMMONS, M. D., in the Chair.

Thiersch's Method of Skin Grafting.—DR. T. W. HUNTINGTON reported the following case, and exhibited the patient: F. B—, watchman, native of New York, aged 40, admitted to the Southern Pacific Company's Hospital May 5, 1892. About 4 years ago, patient received a compound fracture of the left tibia and fibula close to the ankle joint, for which he was treated at a hospital for a year, and when discharged was able to move about on crutches; but never had much use of the limb afterwards, as it always was very tender and enlarged, and troubled him constantly. About two years after the injury an ulcer developed over the seat of fracture, but received no treatment, except from the patient. On admission there was a large ulcer, extending from the ankle joint

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upwards about 7 inches, and about $3\frac{1}{2}$ inches in width, on the external aspect of the leg. The limb was much enlarged. It was thought the ulcer was probably due to some underlying bone trouble; and, accordingly, the limb was thoroughly prepared, and patient etherized, an incision was made down to the fibula, which was found greatly enlarged, an opening was chiseled into the bone, a quantity of pus evacuated, and several small sequestra found. The bone was chiseled out and curetted, and the cavity packed with iodoform gauze, and a careful antiseptic dressing applied. May 30th: Bone cavity filling up nicely, and wound in a healthy condition. June 30th: Cavity filled in; there is still a large granulating area on site of old ulcer. July 6th: Patient has decided to have the ulcer covered with skin grafts from his arm. Both arm and leg were thoroughly cleansed and prepared for operation the previous day. He refused to take an anesthetic. The surface of the ulcer was dissected off, and covered, by Thiersch's method, with skin from the left arm. A covering of strips of oil-silk, cleansed in boracic acid solution, was placed over the grafts, and a moist dressing over all. The arm was also covered with a moist dressing. July 22d: Arm well; leg has been dressed at intervals of 3 or 4 days. The grafts have done well, and ulcer is completely covered. A light dressing applied.

DR. W. R. CLUNESS read a paper entitled: "Appendicitis or Perityphlitis, Which?" (Published at p. 498.)

DR. T. W. HUNTINGTON said, while he conceded the fact that the condition mentioned in the paper might have various causes, as traumatism, penetrating foreign bodies; yet, in a certain proportion of cases, the trouble commenced in the appendix. A catarrhal condition was first produced, resulting in the final explosion or bursting. Other cases, like those mentioned in the paper, had their origin in the surrounding structures.

DR. J. H. PARKINSON said that no doubt many cases were diagnosed as appendicitis that were really not so. It was remarkable how many cases of this disease were being recognized every day, in comparison with those found in former years. This was due, in part, to better diagnosis and differentiation of the disease in its early stages from other abdominal troubles. There remained however, a large number of cases, some of which must be explained by the prevailing craze. The early medical treatment of the disease was most important, as many cases, if seen in time and properly treated, would not require surgical interference.

DR. G. L. SIMMONS: There is apparently very little danger in the operation, and it is easy of performance. The great difficulty is in recognizing the earlier conditions in appendicitis, and an exploratory incision is often imperative.

DR. J. R. LAINE said the paper was a plea for more accurate diagnosis; we can usually exclude traumatism. In a few cases that he had seen operated upon, there has been extracted from the appendix a homogeneous, bean-like mass, having a fecal odor, but not containing any foreign body.

Papilloma and Myoma.—DR. J. H. PARKINSON exhibited two tumors removed from a woman æt. 45. The papilloma, which weighed 213 grs., had been attached to the popliteal space by a slender pedicle, over 2 ins. in length. It had been growing for 27 years. The second tumor was attached to the internal sphincter of the anus by a narrow but quite extensive pedicle. It weighed, when removed, 352 grs. It had given rise to considerable pain and hemorrhage, being extruded at each evacuation. Dr. Albert Abrams, of San Francisco had examined the tumors, and made the microscopical diagnosis. The rectal tumor was evidently recurrent, as a small growth presenting the same characteristics had been removed some years before.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular Meeting, July 12, 1892.

The President, D. W. MONTGOMERY, M. D., in the Chair.

DR. O. V. THAYER read a paper on "Lupus Exedens," giving the history of a case successfully treated by the solar cautery.

DR. J. ROSENSTIRN said he came with the idea of hearing or seeing something new in the treatment of a very obnoxious disease, but was greatly disappointed. He did not wish to condemn the solar cautery but to condemn the man-

ner of presenting the case. There had been no evidence produced excepting two lenses. The subject should have ocular demonstration by the showing of cases or photographs. We are taught that there is something different in the heat produced by the rays of the sun, and in order to believe these things we must have absolute evidence that the disease was lupus.

DR. M. REGENSBURGER said he concurred in the remarks of Dr. Rosenstirn that more evidence than the mere statements should be produced. The sun is a very uncertain quantity in San Francisco, and he could see no advantage over the electro-cautery.

DR. C. G. KUHLMAN said he could not agree with Dr. Thayer as to the etiology or division. Lupus being true tuberculosis of the skin—the cause is specific and there can be no division—and being tubercular cannot be cured, any more than syphilis can be cured; the local manifestation may disappear, but the constitutional still remains.

DR. LUTZ said it is not uncommon to see people that had been cured. He thought that the chemical treatment was the most satisfactory—for instance the use of salicylic acid. We must vary the method of treatment and we are justified in trying to cure.

DR. J. SIMON concurred with Dr. Lutz that cases are cured. He had seen cases that had been cured by scarification.

DR. H. GIBBONS, Jr., said he had used the lens in the destruction of moles, and there might be some good in this treatment.

DR. THAYER, in conclusion, said that the case reported had been presented to the Society some time ago. He did not think anyone should condemn the treatment brought forward until they had investigated.

DR. H. M. SHERMAN exhibited a specimen from an excision of the hip, showing an abscess cavity occupying the neck and head of the femur, without implication of the joint cavity, though the cartilage of the head was undermined and in a short time would have broken through. The course of the case had been rapid, but not otherwise remarkable, nor were the symptoms in any way uncommon.

DR. ROSENSTIRN thought that the case was very interesting, as the diagnosis was made from external evidence alone.

CALIFORNIA ACADEMY OF MEDICINE.

Regular Meeting May 21, 1892.

LUKE ROBINSON, M. D., in the Chair.

DR. T. F. RUMBOLD read a paper on "The Mechanism and Etiology of Tinnitus Aurium" (To be published.)

DR. JAS. SIMPSON said: Twenty years ago matters were different. He had lived in the mountains, pulled teeth, doctored all parts of the body, eye and ear as well, as specialists were not around then, in the city. These cases he now passes to a specialist, and too frequently he had been disappointed when he had done so. He had slept for two years within 20 feet of a quartz mill, and had slept happily. He had never heard the mill and woke when it stopped. He thought there was a good deal in Dr. Rumbold's paper; he accepted it and believed in it. When he was a school teacher, near the Bay of Fundy, he carried the roar of the breakers with him for half the next day.

DR. W. A. MARTIN said, as he had mentioned in his paper read at the last meeting [*vide p. 492*], the main cause was the peculiar conditions of the stiffened ossicles and the new relations the plate of the stapes bears to the labyrinth. Circulation sounds, no doubt, arise from the vessels. There is nothing in the theory that the noise is due to paralysis agitans of the ear muscles, for the most troublesome cases are those in which there is a complete ankylosis and furthermore where caries exists there is no connection with stapes and tensor tympani, and nothing is left but the plate of the stapes. He said he had a case on hand now which had been operated on, and the incus and stapes left in the ear. He removed the stapes but the sound still remained. From the other ear he removed the tensor tympani, took out the hammer, curetted, and still the noise is there, but the hearing is better. This case would tend to support the theory of the vibration of the muscles, as the cause of tinnitus aurium. Of course any vibration transmitted to bones will produce abnormal sounds in the ear.

DR. W. F. THORNE said he had been a victim of tinnitus for many years. Dr. Rumbold's theories were ingenious, but somewhat far-fetched. The most rational theory is that the noise is purely congestive, that is circulatory, at least in those cases where there are no organic changes or disturbance. The tinnitus bothered him more after a day of excessive work, or after indulgence in too much smoking, then the noises in his left ear become almost unbearable, and the hearing about $\frac{1}{4}$ normal. The noises were purely subjective and associated with the outer world simply by suggestion, as for instance, a man who has been hypnotized is told to hold out his hand in a peculiar way, believing that he is fishing; or as lights appear when the finger is pressed on the closed eye-ball. He thought Theobald's theory was good. Where you get ankylosis and caries, you have a disturbance of the circulation in the parts, either a deficiency or an excess.

DR. GEO. GROSS inquired if Dr. Rumbold had used salicylate of soda in the treatment of tinnitus? He had found it useful, probably in the congestive variety.

DR. L. ROBINSON would like to ask Dr. Rumbold what the noise in circulatory tinnitus was due to, say in chlorotic girls. Was it due to the character of the anemic blood or the changes in the blood pressure? Given a condition of blood tension; a healthy person takes quinine or nitrite of amyl. He then experiences a variety of sounds synchronous with the heart's action, in these noises it is the sympathy of the ganglyonic system of the sympathetic.

DR. MARTIN remarked that the anemic noises were supposed to arise from the jugular fossa. It was impossible to describe a sound except by comparison.

DR. THORNE spoke of certain noises being heard during the administration of chloroform. In one case where he had amputated the hand of a railroad engineer, the patient afterwards said that throughout the operation he heard his locomotive puffing along all the time.

DR. RUMBOLD, in replying, said the noises in circulatory tinnitus were certainly due to the blood pressure. There are two kinds of tinnitus: first Theobald's, the organic, which is located in the labyrinth, and secondly, that produced by vibrations communicated from the vessels and due to congestion.

Regular Meeting, June 18, 1892.

LUKE ROBINSON, M. D., in the Chair.

A Reaction with Glymol.—DR. M. HILDEBRAND illustrated a reaction he had accidentally discovered. The Angier Chemical Company had sent him a sample of glymol. He had occasion one day to color some specimens by Gramure's method, when he noticed a peculiar reaction. A solution of iodide of potash, on the addition of a c.cm. or so of nitric acid and the same amount of chloroform gave a pinkish colored zone at the bottom of the test tube. The solution of iodide of potash, to which was added a little glymol, gave the same reaction, only reversed, the zone being at the top instead of at the bottom. He did not offer any explanation for it.

Osteo Sarcoma of the Scapula.—DR. DUDLEY TAIT exhibited an osteo sarcoma of the scapula, which he had removed from a patient. The growth involved the coracoid process and the scapula had been completely excised. There was nothing particular about the operation, only the lack of hemorrhage. In most cases of excision of the scapula the hemorrhage was formidable. Liston, he believed it was, who had encountered a hemorrhage, which almost cost the patient his life, and Billroth deemed it prudent when about to operate, to ligate most of the branches of the sub-scapular artery. In this case the bleeding was comparatively trifling, only two small branches in the infra-spinous fossa, which could be twisted, and one branch that was tied, gave some trouble. The incisions were two; the first parallel to and $\frac{1}{4}$ of an inch outside the spinal border of the scapula extending to the lower angle. The second from the upper end of the first incision outward. There was no difficulty in clearing off the acromion process and passing the chain saw. Disarticulation was readily accomplished, the suprascapular muscle was cleared away and the scapula was removed by the sub-periosteal method. On the eighth day after the operation, a large phlegmonous swelling, probably under the latissimus dorsi, extending down to the crest of the ilium made its appearance. On the ninth

day the patient died suddenly, probably from septic embolism. The speaker also showed an hypertrophied heart; there had been a history of interstitial nephritis, which had terminated by rupture of the left ventricle at the "unguarded spot."

DR. G. F. SHIELDS asked Dr. Tait if in his operation he had allowed the periosteum to remain in the wound; that is, if he had stripped it from the whole scapula, and if so, was he not afraid of a return of the trouble.

DR. TAIT replied that he had only removed the periosteum from the infraspinous fossa.

Multilocular Cyst of the Kidneys.—DR. D. W. MONTGOMERY exhibited two kidneys, which were the seat of multilocular cysts. The kidneys were most enlarged anteriorly, the pelves and ureters were normal. The cysts were arranged, the smaller near the middle, the larger near the periphery. When first taken out the kidneys were variegated, now some of the cysts are citron yellow, some darker, and some of a grumous material. As was usual the disease affected both kidneys in this case. The kidneys were removed at an autopsy in 1890, and he exhibited them on account of the recent cases reported in Europe. They were about even in size; usually one is larger than the other. It is the usual thing to have a cystic degeneration of the liver in such cases, one author in Germany recording 17 out of 63 cases. In the speaker's case there was no lesion of the liver. Multilocular cysts of the kidneys are rather hard to diagnose; in 18 of the above cases the diagnosis was made *ante-mortem*. Many were only known as tumors. If we find a bilateral tumor and can say it is of the kidneys, we can be reasonably sure of the diagnosis. Often when the tumor is large we cannot make it out clearly, as it is of the same consistency as the abdominal walls. If it is bilateral, it pretty certainly excludes hydronephrosis, ecchinococcus and ovarian tumors. The cysts sometimes break and cause a perinephritis. Lumbar pain very similar to nephritic colic may occur, accompanied by hematuria. The left side of the heart may be hypertrophied, though there may be anuria and uremia. A cancer of the kidney would be solid, but rapid in growth, so if a tumor slow in growth is found, one might suspect cystic degeneration. The best sign is the presence of a tumor of the kidneys of small and large cysts, but it cannot generally be obtained, as the tumor is surrounded by a hard fibrous shell. Some claim this a good sign, as then hydro-nephrosis may be excluded, as well as echinococcus. The urine may be normal, but there may be some albumin or a little pus. In one case pus was present, but it was from a pyelitis. The amount of urine and the sp. gr. decreases as the case goes on; this is an important point in excluding some cases of nephritis. In these kidneys the urinary tubules are immense and the cysts seem to grow out of them. It is a regular cystic process, similar to the degeneration of the ovaries. These enlarged tubes and cysts can be seen by a low power, and quite a deal of the kidney tissue is left, enough to carry on their function. [Photos of the kidneys exhibited, taken by Dr. McNutt, and pictures of the multilocular cystic degeneration in Ewald's case, were exhibited.] In "Surgical Affections of the Kidneys and Ureters," by A. Le Deutu, a cut of the disease was also shown. In Ewald's case, the heart was smaller than normal, but death occurred from uremia. The patient was morose; a specimen of the urine could not be obtained, as the woman was menstruating at the time. A few days before death a few ounces were obtained and albumin was found. The termination in all cases is about the same; they die suddenly. One case was brought into the hospital for a wound of the leg. Another was that of a woman who was pregnant and died from the extra work demanded of the kidneys. Another case was one in which a man fell a short distance from a ladder and died. Another followed the use of a catheter. Sometimes we find an abdominal tumor and then a problem occurs. If an operation is performed we find it almost always to involve both kidneys. In 1881 Dr. Burgess operated on a case and found a tumor, evidently originating from the kidney. Dr. Chismore obtained some fluid by puncture of the tumor and discovered urea in it. The tumor decreased in size, but soon filled. Again it was aspirated and some inflammation followed. Then it was suggested to inject iodine, but as the patient was getting low, extirpation was performed and in a few days death ensued. The speaker warned physicians not to confound these cases with small cysts resulting from interstitial nephritis, nor the rare large cystomata of the kidney.

DR. G. F. SHIELDS thought this an excellent warning to surgeons against attempting to remove multilocular cystic kidneys. Some authors say it is the thing to remove them, but if the disease occurs bilaterally, as statistics prove and as Dr. Montgomery says, non-interference is the best surgical procedure.

Regular Meeting, July 16, 1892.

LUKE ROBINSON, M. D., in the Chair.

Diabetes Mellitus.—DR. MAX HILDEBRAND reported the case of a lady who had 6 per cent. of sugar in the urine. He put her on sozo-iodol of sodium, which has been very highly recommended in diabetes mellitus. He gave it in gramme doses, twice daily, morning and evening. He had not been particular as to diet, and had not laid down a strictly anti-diabetic regime, allowing bread, potatoes, and a little wine. The remedy always diminished the sugar, and in six weeks none was present. He did not desire to draw conclusions from one case, but had merely cited it as being peculiar, in the rapid diminution of the sugar after the administration of the drug. In reply to an inquiry, the speaker said she had had diabetes for a number of years, 3 or 4 at least. Every symptom pointed to it, and her external genitals were much eroded from the action of the urine. The aggregate quantity of sugar was about 24 grains to the ounce.

DR. W. F. THORNE said he had some experience in the treatment of diabetes, and had found one of the best and most useful remedies to be salicylate of sodium, in 15 or 20-grain doses, three times a day. He remembered one case, that of a very fleshy woman, who weighed 250 or 260 pounds. She passed 2,200 grains of sugar a day. He laid down a restricted diet, and gave 45 grains of salicylate of sodium a day. The sugar began to diminish, and diminished to 6 grains daily, where it remained for years, the patient enjoying very fair health for this time, when she passed from his hands. It controlled the disease and diminished the sugar to a remarkable degree. Another patient, a Spanish woman, had taken the salicylate almost constantly for ten years, and is in fair health now.

DR. D. D. CROWLEY said for some time he had had a patient under his care who had been seen by Drs. Hirschfelder and Morse. He was suffering from an abscess in the gluteal region, which had dissected quite deeply, probably up to the fascia. Incisions were made and drainage established, and immediately the sugar disappeared from the urine.

DR. DUDLEY TAIT said in Dr. Hildebrand's case, if there was sugar in the urine, and irritation of the external genitals, it was probably glycosuria, and only a symptom. The treatment of diabetes depends upon the source of the sugar; it may arise to a great extent from food. If from this cause, the procedure is to put the patient on a strict diet. One case he had a year ago had 6 per cent. of sugar, which by diet was brought down to 3 per cent.; now there is 1 per cent., and the patient is not well, so the trouble in this case was not from the sugar. Salicylate of sodium improves the digestive functions. The best treatment recognized now is the hygienic, strict attention to the skin and stomach.

DR. GEO. GROSS said that ordinarily the quantitative examination of sugar was difficult, but with a little apparatus, that he hoped soon to exhibit, it was quickly and easily done.

DR. D. W. MONTGOMERY said if sugar in the urine was the only symptom, this was not strictly a diabetic patient. He had used both salts of sozo-iodol in skin troubles, but had gradually eliminated them from his practice, after finding out that they had scarcely any more action than sand. Salicylate of sodium, by improving the digestive apparatus and stimulating the liver, acted beneficially in glycosuria.

DR. HILDEBRAND, in replying, said that the diagnosis of diabetes is contained in the numerous medical works, and that he didn't think anyone would doubt his diagnosis. He had, as a consultant in the case reported, a medical man of high repute in Germany, and did not doubt him. They used polarization, and found it was sugar; it was not levulose or inosite. There was an immense amount of urine passed. The sugar in diabetes, of course, comes from different sources; may be from the liver, or from the fourth ventricle when there are nervous disturbances present. Sozo-iodol produces increased blood pressure. Diabetes from the liver is from a stasis, or when the sugar is formed from a stoppage in the glycogenic function, then, if an increased force of blood is obtained, this may be overcome.

Depressed Fracture of the Superior Maxilla—Elevation of the Fragment from Within.—DR. D. D. CROWLEY reported a case of facial fracture. The patient, a baseball player, had been struck on the malar bone by a baseball. There was a depressed fracture of the malar bone and superior maxilla at their junction. It was impossible to raise the fragments. The floor of the orbit was also displaced, the eye bulging forward; both the nasal and malar processes of the superior maxilla were flattened and depressed into the antrum. The speaker made an opening under the lip, in the canine fossa, into the antrum, an ordinary urethral sound was passed through it, and by carefully manipulating it the malar bone was raised, with the aid of the finger, well back in the zygomatic fossa. There was no subsequent loss of bone, or even suppuration, and the small opening made in the antrum is nearly healed.

DR. DUDLEY TAIT said he had lately a similar one under his care at the French Hospital, but it was that of a pistol shot wound. The bullet entered the left cheek, passed through the maxillary sinus, behind and above the soft palate. The opposite maxilla was trephined, and nothing was discovered. He then trephined behind the inferior branch of the maxillary artery, and found the bullet. The wounds were thoroughly disinfected, and healed completely in five days.

SOCIETY OF MEDICAL OFFICERS AND BOARDS OF MANAGERS OF THE CALIFORNIA HOSPITALS FOR INSANE.

Third Annual Meeting, held at Agnews, July 19, 1892.

The meeting was called to order by the President, F. W. HATCH, Superintendent of Agnews Asylum.

DR. A. M. GARDNER read a paper upon "Mechanical Restraint in the Treatment of the Insane" (published at p. 485).

DR. H. N. RUCKER, of Stockton, said he liked the paper, because the opinions expressed were conservative. If restraint were unnecessary, asylums would be unnecessary. The vicious disposition must be controlled. Many persons are sent to asylums simply to be clothed and fed, but among those committed are some whose mental symptoms and habits are such that, but for the use of some form of mechanical restraint, homicides and suicides would be of frequent occurrence, which would make the public complain of the management. The speaker eulogized the men who removed the shackles from patients kept in dungeons, as was the case in the past, and called attention to the swaying of public opinion of late in the other direction—away from total abolition of restraint. He would, however, recommend to his colleagues the reduction of mechanical restraint to a minimum. He thought restraint a curative measure in many instances.

DR. O. HARVEY, of Galt, thought the make-up of an asylum contemplated restraint. Persons are removed from their own family, because they are unmanageable at home, where they often grow worse. He spoke of an acquaintance who was taken away from home (an act which the public considered cruel); in the asylum at Stockton he soon grew quiet, finding out that he must obey rules, and could not do as he pleased.

The Overcrowded State of California Asylums.—DR. P. SHURTLEFF, of Napa City, spoke of the great number of insane in the State. He said: There are many patients in asylums that should be supported by counties. He thought the counties should be made to bear their share in the support of the patients at the asylums, so that they would be interested in not sending any more patients there than necessary. If the counties scrutinized every expense as they do in New York and Pennsylvania, the people would not complain of having so many insane. Many patients could just as well be taken care of at home, or in the county hospital. Lately a patient had been sent to Napa, who was simply a case of old age. Putting the burden at least in part on the county, he thought, was something needing serious consideration. The speaker compared some statistics (1880), showing the proportion of the insane to the general population in different States, the number cared for in State Asylums, in County Hospitals, alms houses and at home. In New York there were more insane at home than in the asylums. In Vermont there were 1,015 insane persons, of

whom 415 were in asylums and 516 at home. In New England people take more interest in the insane than they do here. In Massachusetts there are nearly as many insane at home as in the asylums; the counties have to pay for every case sent to the asylums. In Pennsylvania the counties pay \$2 to \$3 a week for each patient. If New York were using our system, there would be to-day 20,000 in her insane asylums. We are, in California, gaining 150 patients a year, which, in ten years, would be a gain of 1,500; then another asylum, or perhaps two, would have to be built. It is time some change in the system of commitment be made. In Ohio there are no more insane than in California, and she has three times as many inhabitants. In Illinois they have 1,000 more patients, but not as many at her asylums, with four times as many inhabitants. We cannot afford to go on with our system, when these old States have found a better way of managing. In connection with the commitment of harmless cases, and cases of senility, to asylums, he mentioned the influence of the history of insanity among ancestors upon applications for life-insurance. For instance, the grandmother of an applicant had been sent to an asylum. Though it may have been but a case of old age, the fact of her commitment would have to be stated in the application.

DR. RUCKER said that he was heartily in sympathy with Dr. Shurtleff a year ago. Within the past year New York had, however, passed a law, entitled the State Care Act, which places all insane patients in charge of the State, and Massachusetts was trying to follow New York's example in this direction. The objection was, that the county did not take proper care of the chronic, harmless, filthy cases. California is doing well by her insane. It is a mistaken idea that there is a higher ratio of insanity in this State than elsewhere. The ratio seems larger, because all the insane are cared for by the State, and cases of insanity are not at large to the extent that they are in the East. The last report of the Census Bureau in Washington gives Nevada, New York, Massachusetts, Vermont and Connecticut as having a higher ratio of insane than California. He would recommend that the counties pay for the transportation of the insane, and that they bear one-third to one-half of the expense of caring for them.

At the suggestion of the PRESIDENT a motion was made by Dr. Harvey to have the Superintendents of Napa, Stockton, and Agnews embody the following resolution in their biennial reports: *Resolved*, That it is the sense of this Association that the counties shall pay for the transportation of the insane to the asylums, and that they shall also bear a certain part of the actual cost of caring for the insane. In view of the great diversity of the law governing the different insane asylums, it is recommended that a new law be enacted, which shall be common to all the asylums, and that the law pertaining to the commitment of the insane be made explicit as to the admission of cases considered unfit for the asylum.

Classification of the Insane.—THE PRESIDENT said that at the Agnews Asylum it was often difficult to classify certain cases. Having but six wards for females, the convalescent cases were often obliged to associate with vicious and violent patients, an element of disturbance and irritation to them. He suggested the building of cottages for convalescents as annexes to the existing buildings, giving them better surroundings and more quiet and refined associates. At present patients of the better class are not served with food as would be agreeable to them, etc.; in cottages they could be given more comfort, which might add to the percentage of recoveries.

DR. RUCKER said he agreed in general with the ideas just expressed, but that many thought an associate dining-room had a good influence upon the patients, and that this was in use even in asylums built on the cottage-plan. Some thought eating in common dining-rooms had a stimulating influence, relieving the monotony. He thought the Stockton associate dining-room at the female department was an improvement on the old plan. His objection to the cottage-plan was that it was more difficult for physicians to make their visits.

THE PRESIDENT said the associate dining-room was a good thing in many cases, but that a number of cases could not be brought there that could be taken to the ward dining-room.

DR. A. M. GARDNER, of Napa, spoke of the cottage-plan, making patients producers instead of consumers, and said that at the last meeting of the State Medical Society he had read a paper on this subject [*vide* MEDICAL TIMES, vol.

vi, p. 257]. He thought the insane were not being treated as they could be treated. In the cottage the patient would not so easily be lost sight of, and his wants could be better studied. He was certain the cottage-plan would increase recoveries from 27 per cent. to 37 per cent., and would save to the State \$50,000 annually. It would give the physicians better opportunities to direct their attention to the convalescing patients. He thought no expense should be spared in caring for the convalescing patients.

Improved Facilities for the Care of Acute Cases of Insanity.—DR. A. W. HOISHOLT, of Stockton, thought it was a matter of the greatest importance to be able to give proper hospital care, especially to acute cases, complicated with physical ailments; that this would increase the percentage of recoveries as much as would better care for the convalescing cases. He had mentioned this matter before the State Medical Society. He thought each asylum ought to be provided with a small hospital, properly equipped for surgical and medical treatment, where certain cases could receive thorough care and nursing. As an illustration of this necessity he mentioned a case of primary dementia in a young man of 19, which he had treated at the Stockton Asylum. The patient afterwards was taken sick with pneumonia, and had to be fed and given medicine by the stomach tube for a number of weeks. The father of the patient offered his services as special nurse, attending night and day, and contributing largely to the physical and mental recovery of the patient. Dr. W. F. Pratt had informed him of another case of insanity, complicated with lung trouble, a patient at Agnews Asylum, whose recovery was ascribed to the care of a special attendant, which his ample means had enabled him to procure. The speaker thought the future would develop the necessity of hospital treatment of the insane on a larger scale than the plan proposed, and that the time would probably come when California would follow England's example, where recently a large hospital for acute cases of insanity had been erected in London, managed and equipped on the modern plan of a general hospital.

DR. B. SHURTLEFF, of Napa City, thought it an adjunct of great value to the asylums to have extra arrangements made for the care of the acute and convalescing cases.

DR. W. F. PRATT, of Agnews, read a paper on "Amusement and Employment of the Insane." [To be published.] DR. H. N. RUCKER, of Stockton, said the difficulty he had experienced in finding employment and amusement for patients was that they would not work or play without having some one to lead them. He was going to recommend to his Board to have all the clothing and shoes made in the asylum. At present he was having mattresses made by patients; a tinsmith and broom-maker (patients) made all that was needed at the asylum in these lines.

The following officers were reelected: DR. F. W. HATCH, President, and DR. A. W. HOISHOLT, Secretary.

The Society adjourned to meet at Stockton on the third Tuesday in July, 1893.

SPECIAL CORRESPONDENCE.

LONDON.

[FROM OUR OWN CORRESPONDENT.]

The Sixteenth Annual Meeting of the British Medical Association at Nottingham.—The Admission of Women to the Association.—Experiments on Animals, and the Anti-vivisectionists.—The Pathological Section; the Etiology of Cancer.—The Effect of Female Labor on the Infant Death Rate.—Miner's Nystagmus and Scientific Wrath.—Professor Gairdner on New Drugs and Advertisers.—A New Coca-base, Tropacocaine.—Foreign Visitors.

The British Medical Association has again had a successful annual meeting; to one who has attended these meetings regularly for some years it must be apparent that they are gaining in weight and influence. It is not merely that the attendance is good, but the business of the sections is more serious, and the interest taken in the Congress by the general public is greater. Of course a

very large part of the sectional work is quite beyond the pale of public knowledge, but a good deal remains in which the public do take a reasonably healthy interest, and though this may appear at first sight not altogether desirable, it will be found on examination that the kind of work in which they take interest is debates on matters of hygiene, and on a few other topics as to which most men of intelligence seek to have an opinion.

The chief event of the meeting was the adoption, almost by unanimity, of a modification of the by-laws which will have the effect of admitting women to the Association. The resolution will have to be confirmed by a special general meeting which will meet before this letter can be read, but the assembly at Nottingham was a representative body, inasmuch as it contained men of all ages, and from all parts of the country. Fifteen years ago the question was decided in the negative by a poll of the members, taken by post, and there was an intention to propose another poll, but the feeling of the meeting was so clearly expressed by the reception given to Mrs. Garrett Anderson, who seconded the proposition, that the gentlemen who were prepared to move for a poll, were of opinion that discretion was the better part and held their peace. Mrs. Garrett Anderson is one of two or three ladies who have been members of the Association during the intervening period since the last poll. She had been elected in the ordinary course without the discovery having been made that she was a she; in this, as in most other cases, *beati possidentes*, and she has continued to be a member of the Association and to attend the annual meetings.

A few days before the Association was to meet, a local lawyer, who had offered to entertain in his house a few members attending the meeting (the hotels in the town are notoriously bad and dear), and whose offer had been accepted, wrote a most offensive letter to a local paper to the effect that as the citizens of Nottingham were going to extend their hospitality, they had a right to know that no vivisection should take place, and to know that none of their guests were vivisectioners. He was, of course, made to understand that his hospitality could be dispensed with, but his letter was only the outward overt evidence of a secret agitation fostered by the anti-vivisection societies, who had an active ally in the Duke of Newcastle, a young man who, by the accident of owning a piece of ground upon which a large number of the richer inhabitants of Nottingham have built their houses, has become rich and influential in the district. In consequence of these underhand schemes, it was resolved to bring the question directly before the meeting, and Mr. Jonathan Hutchinson undertook to propose a resolution affirming: "That this general meeting of the British Medical Association records its opinion that the results of experiments on living animals have been of inestimable service to men and to the lower animals, and that the continuance and extension of such investigations is essential to the progress of knowledge, the relief of suffering, and the saving of life." Mr. Hutchinson made a very striking speech, and the resolution was carried by acclamation. The subject is to be further discussed at the Church Congress in October, and it is hoped that this very clear declaration may have the effect of preventing the cooler heads among the clergy from being carried away by the mendacious rhetoric of the foolish people who believe that all doctors are "fiends."

The Section of Pathology is generally said to have been the most successful; immense pains were taken by Professor Victor Horsley, the President, and the other officers of the section, to get together a representative body of pathologists from all parts of the kingdom. Very many of the papers might be more correctly described as demonstrations, the lecture lantern being freely used. The most spirited debate was that on Cancer, which was opened by Dr. Sheridan Delepine, who delivered a severe criticism of the paper recently published by Dr. Ruffer, who believes that he has found the characteristic organism of cancer in a psorosperm contained within the cancer cells. Dr. Delepine, who is Professor of Pathology at Owens College, Manchester, would have none of the parasite; he had seen the appearances himself a couple of years ago; had demonstrated them to the International Congress of Hygiene last year; had since studied psorosperms in the rabbit's liver, and had satisfied himself that these bodies described by Dr. Ruffer were cells contained within others—that is to say, that the appearance was produced by the process of endogenous proliferation. Dr. Ruffer stuck to his guns and had rather the better of his opponent.

in the polemic, but Dr. Delepine's drawings, which he showed by the lantern, if they are faithful, that is, if he has not drawn what he saw with the mind's eye, and not with the eye of flesh, are almost conclusive for his argument.

In the Ophthalmological Section, also, there was a very fierce discussion. The battle ground was miners' nystagmus, and the President of the section, Mr. Priestley Smith, declared at the public dinner of the Association the same evening, that he had difficulty in keeping the peace. There is no dispute as to the facts of the occurrence of the nystagmus, only among the hewers, who have to work in a constrained position and in a bad light. Mr. Snell, of Sheffield, was the first in this country to take up the question seriously, and after prolonged study he came to the conclusion that the affection was due to the fatigue of the ocular muscles, brought about by the strain of keeping the eyes directed upwards and over the shoulder for many hours a day. He showed how, after apparent recovery, the nystagmus came on again at once, when the miner put himself in the attitude for hewing, and he brought forward a great deal more evidence of a weighty kind. Mr. Tatham Thomson, however, brought evidence that the affection might occur in miners who never assumed the peculiar attitude of the coal getters, and then the matter was taken up by the unions, who sought to prove that the cause was the imperfect light. An investigation was made by Dr. Court, apparently for the unions, and his report, which supported the insufficient light theory, was issued in a little pamphlet which was brought directly under the notice of the general public; a discussion was started in the lay press, with no particular result beyond the addition of one more charge against "the masters." The best opinion seems to be that the affection is due to eye-strain, which may be produced either by a constrained attitude or by insufficient light, but generally by the combined action of these two causes.

Dr. George Reid, the Medical Officer of Health of the Staffordshire County Council, made a rather striking statistical communication as to the effect of female labor on the infant death-rate. The county contains two populous areas; the general sanitary condition of the two areas was as nearly as possible identical, but in the south, the main industries are coal mining and iron forges, in neither of which are women employed; whereas, in the north, the main industry is potting, in which a large number of married women are engaged. The work done by women in the potteries is not severe, but it keeps them away from home during long hours (probably eight or nine), and their infants are not suckled during that time. The general standard of comfort is good, and there is nothing like privation. On the whole, therefore, the circumstances appear well chosen to show the effects of hand-feeding on a large scale. The inquiry was confined to towns having a distinctly artisan population; the total population was 438,712. The towns, it was found, fell into three classes, viz.: (1) Towns in which many women were employed in works. (2) Towns in which few women were thus employed; and (3) Towns in which the circumstance was intermediate. The death-rates were calculated on the returns of ten years; the deaths in children under one year, per 1,000 births, were as follows: In towns of Class 1, 195; in towns of Class 2, 166; in towns of Class 3, 152. The deaths from diarrhea, per 1,000 births, were 28, 20, and 19, respectively. The general death-rates were higher in the towns in which women were employed in factories (22.8, 19.4, and 18.1, respectively), and this excess is almost entirely owing to the excess of deaths among infants. Dr. Reid suggested that the facts justified an appeal to the Legislature to extend the present period of one month after confinement during which work is illegal to three months, which would be long enough to give the infants a start in life.

In the Section of Pharmacology and Therapeutics Professor Gairdner, of Glasgow, liberated his soul as to the study of therapeutics by committee, with which he would have no more to do, because the committees either would not form themselves, or would not work when formed, or would not work in the right way. At the same time he delivered a phillippic against the modern system of advertising a new drug or a new combination into favor; the advertising, he said, resulted in a fortune to the advertiser before it had been found out whether the drug was a good one or not. A committee, he thought, or a number of committees in different parts of the country, might find out in a short time what a drug was worth and publish the result, thereby saving much time, trouble, and disappointment, and also doing away with the pernicious practice of signed testimonials. Dr. Chadbourne, of Boston, Mass., brought over a

communication from Leibreich's Laboratory in Berlin on a new coca base—Benzoyl-pseudo-cocaine—which was first obtained from the small-leaved coca of Java by Giesel, and studied by Liebermann. It is to be called Tropacocain, in order to emphasize its relations to cocaine and atropine. Dr. Chadbourn finds that tropacocaine is less than one-half as toxic as cocaine, and produces local anesthesia of eye and skin more quickly and completely than cocaine. Professor Schweigger thinks that the anesthesia does not last quite as long in the eye, but Dr. Chadbourne does not altogether accept this opinion. Iridectomy has been performed in less than two minutes after one or two drops of a 3 per cent. tropacocaine solution had been placed upon the eye, without pain to the patient. Tenotomy has been done in less than half a minute after introducing the tropacocaine. The salt recommended for actual use is synthetically prepared muriate of tropacocaine, which can be obtained apparently not quite pure from Dr. F. Giesel, of the Braunschweig Chinin Fabrik. The great advantage claimed for the drug is the rapidity of its action. Its price was not mentioned, but this is not a scientific detail, and science, of course, knows nothing of trade.

Professor Ebstein attended the meeting also, and recommended a new sort of bread for diabetics. M. Morel, of Belgium, gave a most interesting account of the "service" for the inspection of the mental state of persons confined in prisons of that country. He showed that a very large proportion of the unruly prisoners were found on examination by an expert to be suffering from some form of mental derangement. The curable cases were treated in special wards in the prisons, the incurable transferred to criminal lunatic asylums. Professor Semmola, of Naples, took part in the proceedings of the Section of Medicine; Professors Schroetter and Grüper had an active share in the work of the Section of Laryngology, and were warmly welcomed by many who had been their pupils in Vienna. Professor Osler was also a welcome guest at the meeting, but he took little part in its serious work, being apparently otherwise, and perhaps more agreeably, engaged.

LONDON, August 10, 1892.

GERMANY.

[FROM OUR OWN CORRESPONDENT.]

Approach of Cholera.—The New Military Rifle.—A Case of Onochoresis.—Adulteration of Wine.—An Artificial Spa.—The Anti-vaccination League.

The hot summer months, which generally lie so heavily on everybody in Germany, and especially on correspondents, have this year brought quite a number of sensational occurrences. The daily press perfectly revels in its supply of interesting topics, from Bismarck's numerous glorifications at Kissingen and elsewhere, to the prospects for an international exhibition at Berlin, a crisis in the Ministry, several highly exciting lawsuits, and the threatening approach of that fearful scourge, the cholera. This latter is naturally the most interesting of these subjects, from a medical point of view, although we no longer need to be apprehensive of such terrible results as have been produced by this epidemic in former years. Thanks to the great advances made in sanitary engineering of late, the danger has been considerably diminished. Naturally, in each individual case of the disease, it is the same as formerly for the person who happens to be attacked, but there is far less probability of a large number being seized now, and so the people are generally in a tolerable condition of calmness. A good deal of debate was aroused by the proceedings of the international meeting of sanitary delegates at Venice, where measures for the prevention of the introduction of the disease from India were discussed. It is to be hoped that the method of inspection which was decided upon will prove efficient. But anyhow, the former plan of quarantine was entirely ineffectual, exceedingly annoying, and even directly injurious. Besides, the description given by Dr. Karlinski, of the station for disinfection at El Tor, in Egypt, is simply appalling. No doubt, the sanitary progress noticeable in Germany since the last appearance of cholera, will also do much to diminish the danger. The disposal of sewage, one of the chief causes of the propagation of the disease, has received earnest attention on the part of the authorities. And although opinions are still divided on the subject, some advocating the canal, others the

pneumatic, and still others the irrigatory system by means of *Rieselfelder* or other measures, there is no doubt that we are better off now than formerly. Among the large towns, Hamburg, Danzig, and Munich, have adopted the canal system, and especially in the latter two its benefit has been very great, as is shown chiefly by a marked and steady decrease of the number of cases of typhoid fever. As to measures directly suitable to encounter the present invasion, the *Reichsgesundheitsamt* has, in conjunction with Professor Koch, published a code of rules to be observed by physicians and others, which is likely to prove of much value. One item in this publication well illustrates the difference between our ideas of prophylaxis at present and in former times, viz: the caution against smoking in rooms inhabited by cholera patients. Formerly it was considered a kind of safeguard against infection to keep oneself enveloped in an atmosphere of tobacco-smoke. This we now know to be by no means an efficient method of disinfection, while the cigar itself is a very favorable spot for germs to settle on and thus to be transferred into the mouth.

Another recent topic of much importance and interest, is the effect produced by rifles of the new construction. The possibility of a war with France and the efforts made by certain chauvinistic individuals on the other side of the Rhine to discover, or, if not discoverable, to invent a *casus belli*, are undying themes of the German press. All the more interest was in consequence exhibited when Professor Bruns, at the last surgical congress, described his experiments with the new model on dead bodies of men and animals. This rifle has a range of no less than 4,000 metres, and power to kill with tolerable certainty even at that distance. The projectiles are conical, nearly four times as long as broad, weighing only 15 grammes (about half an ounce), and are covered with a firm shell of steel or copper. By the introduction of the magazine for the cartridges, and the use of smokeless powder, the amount of firing that can be performed in a given time, is thus enormously increased. The new model is therefore evidently a much more powerful weapon in case of war than the old one. As to its effects, considered from a surgical standpoint, these are also decidedly an advance, chiefly because the laceration of soft parts and the splintering of bones is considerably lessened. Long shots, at 800-1200 metres, give a clean-cut wound, as if the parts had been stabbed with a knife; and broad bones are pierced right through, often without any splintering. Hemorrhage, however, is likely to be severe, as the blood vessels are simply severed without being compressed or able to retract. Consequently, internal bleeding will probably often lead to fatal results before it can be reached and controlled. At short distances, up to 400 metres, the effects are pretty much the same as formerly, although certainly rather milder than otherwise. They evince themselves as explosive force, the skull, for instance, being burst entirely asunder by a shot through the forehead. At distances beyond 1,200 metres again, the destructive powers are greater and more dangerous than with the old weapons. But all in all the new rifle is less cruel and inhuman in its effects than the old. In connection with this subject, it is of interest to mention that the idea formerly prevalent, that a bullet is disinfected by the heat produced in the barrel, is quite erroneous. Dr. Messner performed some experiments with the new rifle, in which the shot traversing the barrel receives an impetus which causes it to rotate 2,500 times per second, against 800 rotations of the old style of rifle. He shot bullets previously infected with streptococci through tins containing gelatine, prepared as a nutrient medium, and found that the microorganisms flourished quite as well after having been discharged as before.

At a recent meeting of the Berlin Medical Society, Dr. Hanseemann presented an interesting case of onochrosis. This very uncommon affection was first described by Virchow about twenty-five years ago, but only very few cases have been observed since then. It consists in a blackening of the cartilages and similar parts, bones, sinews, tunica intima of the large blood vessels, etc. Bostroem advanced the opinion that this discoloring was due to hemorrhage and the presence of melanin, but this is not confirmed by the researches of other observers. In this case the patient was a man aged sixty-one years, who had suffered from typhoid fever twenty-eight years ago, and whose urine, since that time, had always been a dark, blackish color. He had never shown symptoms of icterus, or of the presence of biliary calculi. Since last year he had been bed-ridden, death eventually ensuing from an aneurism of the aorta. His urine contained a certain amount of albumin and hyaline casts, but no blood, bile or

indican. The *post-mortem* examination showed the lungs to be but very slightly pigmented, while the lymphatic glands of the abdomen were almost quite devoid of coloring matter. The gall-bladder contained several hundred little concretions of cholesterine. The cartilages of the ribs were throughout of an intensely black color; also, though to a less degree, the intervertebral discs, the cartilages of the knee-joints, symphysis, etc. The mitral valve and the intima of the aorta also presented greyish-black spots. This pigment appeared partly diffused, as in the hyaline and fibrous cartilages, partly in globules. It is different to any other chemical body hitherto known, and is certainly not melanin.

One of the most important bills passed during the last session of the Reichstag is that regulating the manufacture of wine and similar products. German physicians have hitherto not been infected with the vagaries of the total abstinence system, and would be loath to deny themselves, still less their patients, the benefit of a glass of good wine in season. The measures now sanctioned by law are well qualified to prevent all injurious adulterations, at the same time admitting of certain additions which are not deleterious to health, and which the wine-growers have found necessary to render the wine clear, palatable and capable of being stored. The wines from the Rhine and Mosel, with the exception of a few specially favored vineyards, all require, in certain years, the addition of a little sugar or other ingredients to render them at all agreeable. Mark Twain, you will remember, advises visitors to these parts to bring their own vinegar with them, as they will then never feel tempted to drink the native wine. Things are not quite so bad, to be sure, but still, the amount of acid in the product is such as to necessitate measures for diminishing it to a certain degree. This is generally achieved by adding some pure cane sugar before fermentation; or else the surcharge of vinous acid is precipitated by the addition of powdered marble (carbonate of calcium), a method originated by Chaptal some time ago. Besides our own products, a large quantity of foreign wines, especially French ones, is yearly consumed in Germany. Now, these are often prepared by throwing plaster of Paris into the uncleared wine, by which means rapid sedimentation and a beautiful color are obtained. In small quantities, neutral sulphate of potassium is, of course, of no importance, but the decree very justly takes care to state that the quantity contained in ordinary red wine is not to exceed 2 per mille, or 2 grammes in a litre. The so-called *petits vins*, obtained by the method of Petiot, by the fermentation of wine-lees with sugar and an addition of pure wine, as also the wines made from dried raisins, are of more importance as regards political economy than from a medical point of view.

An addition to the chapter of adulterations of a peculiar kind has recently been contributed from Krankenheil-Jölz, a health resort in the south of Bavaria. This promising little place is the possessor of wells containing chiefly iodides besides other useful ingredients, and, owing to its picturesque scenery as well as to the results obtained, it was gradually coming more and more into favor. Now it happened that an enterprising civil engineer discovered a new spring of much higher concentration than the old ones in the vicinity; and as he could not come to a settlement with the company working the wells, he started a new Spa for himself, with the aid of one of the doctors who, it would appear, had had some disagreements with the others. Very soon a number of remarkable cures were published, and everything looked most satisfactory. In the course of last winter, however, we were startled by the communication (afterwards verified in the law courts) that the new well owed its magnificent powers to the artificial addition of various chemicals. The natural supply having suddenly run short, the proprietor had had recourse to this simple, albeit illegal, procedure. There was a tremendous commotion at the time, but now things seem to have settled down again, and the old company, no doubt, feels greatly relieved to be thus delivered of its dangerous competitor.

A little trait, also illustrative of the means to which people working on a false basis will resort to, was displayed a short time ago at a meeting of the anti-vaccinationists in Eisleben. Sad to say, there are a rather large number of persons and even doctors in Germany who are so obtuse as not to be able to comprehend that vaccination is an inestimable boon to humanity. Among these is a Dr. Hübner, who has written a pamphlet against it. When the first son of our present emperor was born, Dr. H. sent him, then Prinz Wilhelm, a copy of

his book, and he had the audacity to inform his hearers at Eisleben that, as a result of his advice, none of the princes of the imperial family were submitted to vaccination. Before long, however, this assertion was shown by an official publication in the *Reichsanzeiger* to be a lie direct.

August 6, 1892.

CORRESPONDENCE.

Large Brains.

Sir: I notice in the San Francisco *Examiner*, of August 2, 1892, an account of "Maynard's large brain," which is reported to have weighed "sixty-four ounces." In the article the statement is made that "there are only four brains on record that were heavier than that of Maynard's." It may be of interest to mention two large brains that I removed several years ago, both weighing more than Maynard's. While on duty at the New York City Lunatic Asylum, in the year 1867-68, Dr. F. C. Wilson, now of Louisville, Ky, and myself made a *post-mortem* examination of one of his patients, a female epileptic, an inmate of the Epileptic and Paralytic Hospital. I removed the brain and found that it weighed 68 ozs. We foolishly sliced it up with a brain-knife, expecting to find something to account for its great weight, but did not discover anything abnormal to the naked eye. The other case was that of a patient in the Charity Hospital, New York. While an interne there in the year 1869, I removed a brain that weighed 65½ ozs. The patient had been under my care in the syphilitic wards. He was a Frenchman, and said to be of noble birth, but who had left his native land and friends, and was working in New York as a decorator. He was said to have acquired his profession in a surprisingly short time. Dr. Wilson was also present at this autopsy, and we decided not to slice this brain as we had done the other. It was exhibited by my visiting surgeon, Dr. Hewit, before the New York Pathological Society, Jan. 27, 1869, and is reported in the *Medical Record* of March 1, 1869. I am, etc.,

ST. HELENA, CAL.

WM. J. G. DAWSON.

REVIEWS AND NOTICES.

ANNUAL OF THE UNIVERSAL MEDICAL SCIENCES. Vols. I to V; issue for 1891. Philadelphia: F. A. Davis.

The "Annual" has this year appeared much earlier than any previous issue, and the editor, Dr. Sajou, says that but for difficulties that were encountered it would have been in the hands of the profession still earlier. A careful perusal of these volumes shows that the work is steadily improving, a more general smoothness and harmony characterizing the various departments. We note two typographical errors in proper names in Vol. IV, but the work on the whole is remarkably free from mistakes. We understand that Dr. Sajou has gone abroad, with the intention of issuing a contemporaneous edition of the "Annual" in French. In this distinctly new departure, for an American firm, we wish the editor and his publishers the fullest success. In its own country, the future of this great book is apparently assured, and we observe with satisfaction, that the obnoxious advertisements have almost disappeared.

A NEW PRONOUNCING DICTIONARY OF MEDICINE. By John M. Keating, M.D., Fellow College of Physicians of Philadelphia; Visiting Obstetrician to the Philadelphia Hospital; Lecturer on Diseases of Women and Children, etc, And Henry Hamilton, author of "A New Translation of Virgil's *Æneid* into English Rhyme," etc. With the collaboration of J. Chalmers Da Costa, M. D., and Frederick A. Packard, M. D. Philadelphia: W. B. Saunders; pp. 818. Price, cloth, \$5; sheep, \$6.

It is impossible to adequately review a dictionary, the value of which is only to be learned by constant use. Of the volume before us, it can be said that it is printed in the clearest and plainest of type, though, perhaps, of a size larger

than is needed by the average reader. The paper is extra heavy, which, while adding to the size of the book, produces a very handsome effect. There are no tables in the dictionary proper, muscles, nerves, etc., being grouped together in the text. This plan has also been followed in the enumeration of the mineral springs; and, indeed, is the rule throughout. The work is certainly up to date, including, as it does, the very newest terms. In accuracy and pertinence of definition, we commend especially the words "allopath," "homeopath," "eclectic," etc.; the meanings attached being more explicit than any we have seen. The appendix, of almost 100 pages, contains a vast amount of miscellaneous information, and copious tables of the bacteria, etc. As a modern dictionary of reasonable size, it compares favorably with any of the recent issues, while in its general style and appearance it surpasses all its competitors.

PYE'S SURGICAL HANDICRAFT; A Manual of Surgical Manipulations, Minor Surgery, and other matters connected with the work of House Surgeons and Surgical Dressers, with 300 illustrations on wood. First American from the third London edition. Revised and edited by T. H. R. Crowle, F. R. C. S., Surgical Registrar to St. Mary's Hospital; and Surgical Tutor and First Lecturer on Practical Surgery in the Medical School. New York: E. B. Treat & Co.; pp. xx-594. Price, sheep, \$4.

The author's idea in presenting this work, as stated in the title, is to furnish an accurate and condensed guide for the use of dressers, house officers and junior surgeons, who deal largely with emergencies. Naturally such a volume must treat in the main with the mechanics or *technique* of surgical handicraft; and in this respect Pye's manual possesses many excellencies. While much that is elementary and simple is brought out under every subdivision, yet abbreviation would in the main have detracted from the merit of the book. The first section on the arrest of hemorrhage discusses every variety of this emergency, whether external or internal, and reference is had to all the procedures known for its relief, both mechanical and therapeutic. The second section treats of bandages and the art of bandaging. Herein this topic, much neglected in works on general surgery, is clearly demonstrated and admirably illustrated. A most valuable chapter is that which treats of retention and extravasation of urine. Every possible condition which may arise in connection with this subject is fully analyzed, and it is probable that few experienced surgeons will read these pages without acquiring new and valuable assistance in dealing with these most unfortunate cases. The book throughout is well written and bears the imprint of systematic, painstaking effort, both in its original plan and its revision.

THE CHINESE—THEIR PRESENT AND FUTURE—MEDICAL, POLITICAL, AND SOCIAL. By Robert Coltman, Jr., M. D., Surgeon in charge of the Presbyterian Hospital and Dispensary at Teng Chow Fu; Consulting Physician to the American Southern Baptist Mission Society. Illustrated with 15 photo-engravings. Philadelphia: The F. A. Davis Co. pp. 220. Extra cloth, \$1.75.

This is a well written book of over 200 pages, illustrated with 15 fine photo-engravings descriptive of the author's experiences and observations in Central and Northern China. The first seven chapters contain an account of his voyage across the Pacific Ocean, his first impressions, and his journey to the interior. The two following chapters are devoted to the diseases prevalent in China, and it is with these that we are most concerned. Drunkenness is a rare sight, probably owing to the fact that those who indulge to excess are looked down upon to such an extent that they are compelled to respect the weight of public opinion. Tobacco smoking is universal. Sociability does not exist among the upper classes as in America and England. Inquisitiveness is a marked characteristic, rendering privacy of any sort almost impossible. Diseases of alimentation are very general, doubtless owing to the ingestion of improperly cooked and innutritious food. By far the largest part of every community is composed of the laboring class who can scarcely earn sufficient to subsist upon, hence they have to eat large quantities of poor food. The infant mortality, largely due to improper feeding, would astonish the world if known. No attention is paid to the laws of hygiene. They appear, however, to appreciate the danger of drinking impure water, and therefore it is always boiled before being drunk, or they use tea or coffee instead. Malaria is everywhere

present, and as its effects are usually manifested upon the chylopoietic viscera, it is probable that more or less of the diseases of the digestive organs are due thereto. Eye diseases of all sorts, except glaucoma, are frequent. Chronic nephritis is also common, while diabetes is somewhat rare. Enlargement of the spleen is frequently met with, even in sections in which malaria is rarely known, and is invariably fatal. As in all other countries diseases of the lungs vary with the location according to altitude and humidity. In some sections of the interior consumption is seldom met with. A non-malignant form of stricture of the esophagus is common, and may be due to a peculiar form of alcoholic drink indulged in, or, what is more probable, has a syphilitic origin. Its amenability to treatment by dilatation and specific medication lends probability to this view. Contrary to what would be expected, typhoid fever is rare, doubtless owing to the almost universal use of boiled water for drinking purposes. "Foreigners" who drink unboiled water are laughed at. Relapsing fever is common and fatal. Epidemics of cholera occur frequently and are attended with "frightful mortality." Whooping-cough is quite rare; also acute rheumatism, although common in its chronic form. Cardiac affections are rare. Yellow fever and dengue are unknown. Dysentery is very common and fatal among foreigners. Mania, dementia, hysteria, epilepsy, hemiplegia, and paraplegia are more common than in America or Europe. *La grippe* was undoubtedly milder than with us, or than in the East or European countries. The various forms of tumor—benign and malignant—are said to be no more common than in the United States. Diseases incident to childbirth are attended with great fatality, owing to the ignorance of the attendants, who are invariably old women. Leprosy exists in every province of the Empire, yet it does not appear to have materially increased in any, hence it is not regarded as actively contagious or infectious, otherwise the Chinese as a nation would long ago have been swept from the face of the earth. Those affected are in no wise restricted or deprived of their liberty. Men have it more frequently than women. The author believes in its hereditary tendency, and has no doubt that syphilis, which is very common, predisposes.

HISTORY OF CIRCUMCISION FROM THE EARLIEST TIMES TO THE PRESENT; MORAL AND PHYSICAL REASONS FOR ITS PERFORMANCE, WITH A HISTORY OF EUNICHISM, HERMAPHRODISM, ETC., AND OF THE DIFFERENT OPERATIONS PRACTISED UPON THE PREPUCE. By P. C. Remondino, M. D., Member of the American Medical Association, of the American Public Health Association, etc.; Physicians and Students' Ready Reference Series. Philadelphia: F. A. Davis; pp x-346. Cloth, \$1.25; paper, 50 cents.

Dr. Remondino has placed before the reading public a work of which he may well be proud. He is evidently an enthusiast on this subject, and the careful reader of his text will soon find himself brought to a similar mode of thought. Not the least interesting is the author's preface, in which he defends features of the work, in placing before the public a book which prudish persons class as immoral.

MEDICAL NEWS.

LICENTIATES OF THE BOARD OF EXAMINERS.

At a meeting of the Board of Examiners, held Aug. 2, 1892, the following physicians having complied with the law and the regulations of this Board, were unanimously granted certificates to practise medicine and surgery in this State:

Ezra T. Abbott, University; Med. Dept. Univ. Michigan, June 30, '92.
Winslow Anderson, (2d certificate). San Francisco; Royal Coll. Surg., London, Eng., Apr. 16, '91; Licentiate Soc. Apothecaries, London, Eng., July 15, '91; Licentiate Royal Coll. Phys., London, Eng., July 30, '91; Member Royal Coll. Phys., London, Eng., July 30, '91.
Edwin Blakeslee, Los Angeles; Berkshire Med. Coll., Mass., Nov. 21, '54.
E. J. Boseke, San Francisco; Chicago Med. Coll., Ill., Mar. 26, '89.
Anna W. Croacher, San Francisco; Med. Dept. Univ. Michigan, June 26, '91.
Charlie Albert Curl, Palm Springs; Chicago Med. Coll., Ill., Mar. 24, '85.
Francis Dean, Santa Clara; Royal Coll. Surg., England, 1884.
W. A. Dunton, Los Angeles; Med. Dept. Univ. So. California, May 25, '92.
John J. Gaynor, Arcata; Coll. Phys. and Surg., Buffalo, N. Y., May 31, '81.
E. S. Goodhue, Riverside; Rush Med. Coll., Ill., Mar. 29, '92.
Mary E. Hagadorn, San Francisco; Med. Dept. Univ. So. California, May 25, '92.
Christian Jacob Heyn, Chicago, Ill.; Univ. of Copenhagen, Denmark, Oct. 10, '84.
Charles F. Knoblauch, Anaheim; Med. Dept. Tulane Univ. La., Mar. 20, '74.

L. Kossuth Lamb, Los Gatos; Med. Coll. of Ohio, Mar. 2, '76.
 Geo. H. Long, Merced; Kentucky School of Med., June 30, '91.
 Frank E. Luman, San Francisco; Bellevue Hosp. Med. Coll., N.Y., Mar. 28, '92.
 Adolph Lutz, San Francisco; Fac. of Med., Berne, Switzerland, July 28, '80.
 James C. McGuire, San Francisco; McGill Univ. Fac. of Med., Montreal, Canada, Apr. 1, '91.
 John H. Pitblado, Los Angeles; Long Island College Hosp., N.Y., Mar. 23, '92.
 Thomas W. Prose, Fall River Mills; Columbus Med. Coll., Ohio, Mar. 9, '84.
 Elmer Newell Tiffany, Watsonville; Med. Dept. State Univ., Iowa, March 7, '88.
 Gerrard George Tyrrell, Jr., Sacramento; Med. Dept. Univ. Vermont, July 11, '92.
 Wm. N. Wade, Santa Barbara; Med. Dept. Univ. Pennsylvania, May 6, '92.

CHAS. C. WADSWORTH, Secretary.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army (Division of the Pacific), from July 21, 1892, to August 20, 1892.

The leave of absence on Surgeon's certificate of disability, granted Captain Marcus E. Taylor, Assistant Surgeon, U. S. Army, is extended four months on Surgeon's certificate of disability.

Captain Leonard Wood, Assistant Surgeon, will accompany the 1st Infantry, under orders to proceed to, and establish a camp of instruction at Santa Cruz, Cal., as medical officer of the command. He will report to Colonel William R. Shafer, 1st Infantry, accordingly. Par. 2, S. O. 84, Dept. of California, August 1, 1892.

The journeys performed by Captain R. R. Ball, Assistant Surgeon, from Fort Townsend to Seattle, Wash., and return, on July 7, 14, 20, 25 and 30, 1892, on public business in connection with the examination of recruits, in obedience to instructions from these headquarters dated April 5th, 1892, are confirmed. Par. 1, S. O. 112, Dept. of the Columbia, August 3, 1892.

Under the requirements of Army Regulations 1662, and letter from the Adjutant General of the Army of March 4, 1892, Colonel Joseph R. Smith, Surgeon, Medical Director, will make an inspection of Fort Bidwell, Cal., and, on the completion thereof, return to his station in this city. Par. 2, S. O. 87, Dept. of California, August 9, 1892.

During the temporary absence of the Medical Director of the Department, Captain William L. Kneeder, Assistant Surgeon, will take charge of his office. Par. 1, S. O. 89, Dept. of California, August 15, 1892.

In accordance with the provisions of paragraph 1662, Army Regulations, as amended by general orders No. 38, series 1890, headquarters of the Army, Lieutenant-Colonel Charles C. Byrne, Surgeon, Medical Director, will proceed to, and inspect the medical department at Fort Canby, Wash. Upon completion of this duty Lieutenant-Colonel Byrne will return to these headquarters. Par. 1, S. O. 104, Dept. of the Columbia, July 21, 1892.

Under the requirements of Army Regulations 1662, and letter from the Adjutant General of the Army of March 4, 1892, Colonel Joseph R. Smith, Surgeon, Medical Director, will make an inspection of Angel Island, Cal., and, on the completion thereof, return to his station in this city. Par. 1, S. O. 85, Dept. of California, July 25, 1892.

At such times as the Medical Director of the Department may be required to be absent from his office on inspection duty, Captain William L. Kneeder, Assistant Surgeon, will, upon timely notification by the Medical Director, in addition to his duties as medical officer at Fort Mason, perform those of attending surgeon for officers on duty in this city. Par. 3, S. O. 81, Dept. of California, July 25, 1892.

First Lieutenant Paul Shillock, Assistant Surgeon, will proceed from Fort Grant to San Carlos, A. T., for temporary duty during absence in the field of 1st Lieutenant Nathan S. Jarvis, Assistant Surgeon. Upon completion of the duty assigned, Lieutenant Shillock will return to his proper station. Par. 2, S. O. 97, Dept. of Arizona, July 28, 1892.

Under the requirements of Army Regulations 1662, and letter from the Adjutant General of the Army of March 4, 1892, Colonel Joseph R. Smith, Surgeon, Medical Director, will make an inspection of Fort Mason, Cal., and, on the completion thereof, return to his station in this city. Par. 2, S. O. 83, Dept. of California, July 29, 1892.

ITEMS.

The **Chicago Medical Recorder**, edited by Dr. Archibald Church, and previously published by W. T. Kener, of Chicago, is now being published by the M. H. Kauffmann Medical Publication Company.

Dr. W. Watt Kerr has returned from his European trip and resumed his practice in San Francisco. He has removed his office and residence from 600 Sutter street to 528 Sutter street. This change was necessitated by the destruction of the former premises to make room for the new building of the Bohemian Club. The unlooked-for removal unfortunately shortened the doctor's stay abroad.